



GAHAR Handbook for HOSPITAL ACCREDITATION STANDARDS



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Table of Contents

Foreword	4
Introduction	5
Scope of this Handbook	6
Purpose	7
Reading and Interpretation of the book	8
Used Language and Themes	10
Accreditation Overview	11
How to apply for a GAHAR survey?	13
Look back period	14
Scoring Guide	15
Accreditation Decision Rules	16
Acknowledgments	17
Acronyms	19
Section 1: Accreditation Prerequisites and Conditions	23
<i>Transparent and ethical relationships</i>	24
<i>Sustaining compliance with accreditation standards</i>	26
Section 2: Patient-Centered Standards	28
GAHAR Safety Requirements	31
GAHAR Safety Requirements Keywords	32
Patient-Centeredness Culture	33
<i>Planning and protecting the patient-centeredness culture</i>	37
<i>Empowerment and involvement of patients and their families</i>	40
<i>Ensuring the patient's physical comfort</i>	46
<i>Protecting patient's belongings, privacy, and confidentiality</i>	47
<i>Responsiveness to patients' and families' voices</i>	50
Access, Continuity, and Transition of Care	52
<i>Effective and safe patient flow in the hospital</i>	56
<i>Effective and safe patient flow within the hospital</i>	60
<i>Effective and safe patient flow out of the hospital</i>	68
Integrated Care Delivery	72
<i>Sustaining uniform care</i>	79
<i>Effective emergency and outpatient services</i>	80
<i>Effective basic screening and assessment of hospitalized patients</i>	83
<i>Patient-tailored screening, assessment, and care processes</i>	85
<i>Effective care for hospitalized patients</i>	93
Critical and Special Care Services	101
<i>Critical Care</i>	106
<i>Specialized Care</i>	111
Diagnostic and Ancillary Services	123
<i>Medical Imaging</i>	131
<i>Efficient planning and management of radiological services</i>	131
<i>Effective operational processes of medical imaging</i>	134
<i>Safe medical imaging studies</i>	138
<i>Clinical Laboratory</i>	140
<i>Appropriate planning and management</i>	140

<i>Effective operational processes in the laboratory</i>	144
<i>Safe laboratory services</i>	153
<i>Effective Point of care testing</i>	154
<i>Blood Transfusion Services</i>	155
<i>Efficient planning and management of blood bank</i>	155
<i>Effective operational processes of blood transfusion service</i>	156
<i>Surgery, Anesthesia, and Sedation</i>	162
<i>Safe and effective surgical and invasive procedures care</i>	169
<i>Safe and effective anesthesia care</i>	179
<i>Safe and patient-centered sedation services</i>	186
<i>Medication Management and Safety</i>	191
<i>Effective planning and management of medication</i>	196
<i>Efficient medication selection and procurement</i>	198
<i>Safe medication storage</i>	199
<i>Safe medication preparation and dispensing</i>	207
<i>Safe medication administration</i>	211
<i>Effective medication monitoring</i>	212
Section 3: Organization-Centered Standards	216
<i>Environmental and Facility Safety</i>	217
<i>Effective leadership and planning of environment and facility safety</i>	223
<i>Safe fire planning</i>	225
<i>Safe hazardous materials and waste management plan</i>	228
<i>Safety and security planning</i>	230
<i>Safe medical equipment</i>	233
<i>Safe utility plan</i>	235
<i>Safe emergency preparedness plan</i>	237
<i>Infection Prevention and Control</i>	240
<i>Efficient structure of the infection prevention and control program</i>	247
<i>Safe standard precautions</i>	250
<i>Safe transmission-based precautions and precautions for immunocompromised hosts</i>	260
<i>Safe laundry and healthcare textile management</i>	265
<i>Effective epidemiological surveillance and monitoring</i>	266
<i>Safe food services</i>	269
<i>Organization Governance and Management</i>	272
<i>Effective governing body</i>	276
<i>Effective organization direction</i>	278
<i>Effective departmental leadership</i>	284
<i>Efficient financial stewardship</i>	285
<i>Safe, ethical, and positive organizational culture</i>	289
<i>Ensuring staff well-being and health</i>	291
<i>Community Assessment and Involvement</i>	294
<i>Effective community services</i>	297
<i>Alignment with healthcare eco-system changes</i>	300
<i>Promotion to the community stakeholders</i>	303
<i>Workforce Management</i>	305
<i>Efficient workforce planning</i>	310
<i>Efficient staff filing process</i>	314
<i>Effective orientation program</i>	315
<i>Effective training and education</i>	317
<i>Equitable staff performance evaluation</i>	318
<i>Efficient medical staff structure</i>	319
<i>Organized nursing structure</i>	325
<i>Information Management and Technology</i>	328
<i>KW: Patient's Medical record Management</i>	330
<i>KW: Patient's Medical record Management</i>	330
<i>Effective information management processes</i>	332

<i>Effective quality management system</i>	334
<i>Patient-centred confidentiality and security of information</i>	336
<i>Availability of patient-specific information</i>	339
<i>Effective patient's medical record management</i>	340
<i>Effective information technology in healthcare</i>	341
Quality and Performance Improvement.....	344
<i>Effective leadership support</i>	349
<i>Efficient department-level input and participation</i>	352
<i>Efficient data management</i>	353
<i>Efficient risk management program</i>	357
<i>Sustaining improvement</i>	361
Section 4: Academic and Teaching Hospitals.....	364
<i>Hospital strategic management supports clinical education</i>	367
<i>Clinical education in support of patient's rights and safety</i>	369
<i>Equitable and efficient clinical education</i>	371
<i>Equitable and efficient research program</i>	373
Survey Activities and Readiness.....	376
Glossary	387
References.....	400

Table of Changes

Summary of Changes Chapter 1.....	23
Summary of Changes Chapter 2.....	34
Summary of Changes Chapter 3.....	53
Summary of Changes Chapter 4.....	73
Summary of Changes Chapter 5.....	102
Summary of Changes Chapter 6.....	125
Summary of Changes Chapter 7.....	163
Summary of Changes Chapter 8.....	192
Summary of Changes Chapter 9.....	218
Summary of Changes Chapter 10.....	241
Summary of Changes Chapter 11.....	273
Summary of Changes Chapter 12.....	295
Summary of Changes Chapter 13.....	306
Summary of Changes Chapter 14.....	329
Summary of Changes Chapter 15.....	345
Summary of Changes Chapter 16.....	365

Foreword

In our dedicated pursuit of healthcare reform excellence, we strive to build a safety culture expressed in internationally recognized quality standards. The General Authority for Healthcare Accreditation and Regulation (GAHAR) is proud to present the second edition of GAHAR Handbook for Hospital Accreditation Standards, 2025. This updated edition reflects the latest advancements in patient safety practices and concepts, offering both accredited and non-accredited organizations valuable insights to identify pressing safety risks and pursue continuous quality improvement.

Healthcare quality is gaining increasing attention in the global context, particularly in light of the Sustainable Development Goals (SDGs). The SDGs underscore the necessity to “achieve universal health coverage, including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.” This imperative is highlighted in World Health Organization (WHO) reports published in 2018.

GAHAR Handbook for Hospital Accreditation Standards, 2025 incorporates the latest advancements in quality improvement science and patient safety, addressing emerging trends and best practices in healthcare. As we continue this journey to elevate healthcare delivery, we remain unwavering in our commitment to upholding the highest standards of quality, safety, and patient-centered care.

We trust that this revised edition of GAHAR hospital standards will serve as both a significant challenge and a clear roadmap for every hospital in Egypt, Middle East, and Africa as they embark on their quality journey, ensuring safer healthcare for all.

Introduction

Welcome to the second edition of GAHAR Handbook for Hospital Accreditation Standards, 2025, a comprehensive guide designed to support healthcare organizations in their pursuit of excellence. This revision reflects our commitment to enhancing healthcare delivery by providing clear, actionable standards that empower hospitals to achieve the highest levels of quality, safety, and patient-centered care.

This edition has been thoughtfully developed based on feedback from our customers and the consensus of experts. We have drawn on valuable insights gained from the implementation of the first edition, the GAHAR Handbook for Hospital Accreditation Standards, 2021. The development process was a collaborative effort involving representatives from various health sectors, including the Ministry of Health and Population, the private sector, university faculty, and professional syndicates. Each chapter has been meticulously reviewed and updated to address the evolving needs of today's healthcare environment.

The handbook approaches healthcare delivery from two key perspectives:

- **Patient-Centered Perspective:** This adopts Picker's model for patient-centered care, ensuring that healthcare organizations are responsive to patients' needs.
- **Organization-Centered Perspective:** This highlights the essential aspects of creating a safe and efficient workplace that supports high-quality care.

The handbook is organized into four major sections:

1. Accreditation Prerequisites and Conditions
2. Patient-Centered Standards
3. Organization-Centered Standards
4. Academic and Teaching Hospitals: (when applicable), This section provides a framework for improving the quality of education and outcomes in academic and teaching hospitals.

These sections are divided into 16 chapters, each focusing on critical aspects of hospital operations. The structure is designed to ensure that healthcare organizations not only meet the needs and preferences of patients but also create a safe, efficient, and supportive environment for healthcare providers.

This handbook encompasses the full spectrum of quality as defined by the Institute of Medicine, which prioritizes patient safety and encompasses the six STEEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered. By adhering to these principles, we aim to foster a healthcare system that consistently delivers high-quality care.

Central to this handbook are the 29 GAHAR Safety Requirements (GSRs), which serve as a roadmap for creating a safer healthcare environment. These requirements are foundational to improving patient safety and are integral to the accreditation process.

This version aims to streamline the content, improving clarity and focus while retaining the essential details.

Scope of this Handbook

These standards apply to the hospitals (as a whole organization) seeking to be accredited by the General Authority for Healthcare Accreditation and Regulation (GAHAR):

Inclusions

These standards are applicable to

- Ministry of Health and Population hospitals
- Military hospitals
- Police hospitals
- Sectorial hospitals
- Private hospitals
- Charity hospitals
- Academic hospitals
- Teaching hospitals

Exclusions

These standards are not applicable to

- Day-care hospitals
- Long-term care facilities
- Mobile hospitals and medical caravans
- Non-allopathic systems of medicine
- Alternative medicine streams
- Wellness centers
- Virtual hospitals

Purpose

GAHAR standards describe the competent level of care in each phase of the patient care process. They reflect a desired and achievable level of performance against which a hospital's actual performance can be compared. The main purpose of accreditation standards is to direct and maintain safe healthcare practice through these standards. Additionally, they foster continuous improvement through the identification and rectification of performance gaps.

These standards also promote and guide organization management. They assist staff, management team, and the hospital as a whole to develop safe staffing practices, delegate tasks to licensed and unlicensed staff members, ensure adequate documentation, and even create policies for new technologies. Compliance with GAHAR standards guarantees hospital accountability for its decisions and actions. Many standards are patient-centered and safety-focused to promote the best possible outcome and minimize exposure to the risk of harm. These standards encourage hospital staff to persistently enhance their knowledge base through experience, continuing education, and the latest guidelines. Ultimately, the handbook seeks to elevate the overall standard of healthcare delivery by providing a structured approach to accreditation, ensuring patient-centered care, and promoting accountability among healthcare providers.

Reading and Interpretation of the book

- The General Authority for Healthcare Accreditation and Regulation evaluates the organization's structure, process, and/or outcome by setting standards that address these concepts.
- This book is divided into four sections, in addition to the foreword, introduction, Scope of this handbook, Purpose, Use, Acknowledgments, Acronyms, Survey activities and readiness, Glossary and References.
- Each section is divided into chapters when applicable.
- Each chapter has:
 - An introduction that contains an overall intent.
 - purpose that details follow the introduction, and each one has a standard or more.
 - Summary of changes to the chapter.
- A standard is a level of quality or achievement, especially a level that is thought to be acceptable; it is composed of a standard statement, keywords, intent, survey process guide, evidence of compliance, and relevant standards.

Standard Components

- Standard Statement:
 - In this handbook, each standard is written as a standard statement preceded with a code.
 - Each standard is followed by a *non-black-scripted statement* that describes the essential quality dimension(s) addressed by the standard.
- Keywords
 - To help organizations understand the most important element of standard statements, as these are words or concepts of great significance. It answers the question of WHAT the standard is intended to measure.
- Intent:
 - Standard intent is meant to help organizations understand the full meaning of the standard.
 - The intent is usually divided into two parts:
 - Normative: that describes the purpose and rationale of the standard provides an explanation of how the standard fits into the overall program. It answers the question of WHY the standard is required to be met.
 - Informative: is meant to help organizations identify the strategy to interpret and execute the standard. It answers the question of HOW the standard is going to be met.
 - Some standards require the implementation of minimum components of processes to be documented, implemented, recorded, and/or monitored. These components are usually preceded with the phrase "at least the following", followed by a numbered/lettered list of requirements. Hence, these elements are considered essential, indivisible parts of compliance with the minimum acceptable standard.
- Evidence of compliance (EOCs):
 - Evidence of compliance of a standard indicates what is reviewed and assigned a score during the on-site survey process.
 - The EOCs for each standard identify the requirements for full compliance with the standard as scoring is done in relation to "Met EOCs".
- Survey process guide:
 - facilitates and assists the surveyors in the standard's rating for the required EOCs.
- Related standards:

As healthcare is a complex service, each standard measures a small part of it. To understand what each standard means in the overall context of healthcare standards, other standards need to be considered as well.

- Standards are categorized and grouped into three sets of groups:
 - Chapters, where standards are grouped as per uniform objective.
 - Quality dimensions, where each standard addresses a particular quality dimension, and strategic categorization of standards to analyze their quality characteristics.
 - Documentation requirements, where some standards require certain types of documents

Used Language and Themes

This handbook used certain themes and vocabulary to ensure uniformity and clarity; These are the most important ones that will help hospitals to interpret the standards: Process, Policy, Procedure, Program, Plan, Guideline, Protocol

Whenever 'Process' is used in a standard, it indicates a requirement that is necessary to follow.

- 'Process'
A series of actions or steps taken in order to achieve a particular end.
- 'Documented Process'
A document that describes the process and can be in the form of policy, procedure, program, plan, guideline, or protocol.
- Policy:
 - A principle of action adopted by an organization.
 - It usually answers the question of what the process is.
 - It is stricter than guidelines or protocols.
 - It does not include objectives that need to be met in a certain timeframe.
- Procedure:
 - An established or official way of doing something.
 - It usually answers the question of how the process happens.
 - It is stricter than guidelines or protocols.
 - It does not include objectives that need to be met in a certain timeframe.
- Plan:
 - A detailed proposal for doing or achieving something.
 - It usually answers the question of what the goal is, why, how it is going to be achieved, and when.
 - It includes objectives that need to be met in a certain timeframe.
- Guideline:
 - A general rule, principle, or piece of advice.
 - It usually answers the question of what the process is and how it should happen.
 - Usually, it is more narrative than protocol.
- clinical care program:
 - A structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions according to clinical guidelines and protocols.
- Protocol:
 - A best practice protocol for managing a particular condition, which includes a treatment plan founded on evidence-based strategies and consensus statements.
 - Usually, it has graphs, flow charts, mind maps, and thinking trees.

1) Document versus Record

- Document:
Created by planning what needs to be done.
- Record:
Created when something is done.

2) Physician Versus Medical staff member

- Physician:
A professional who practices medicine
- Medical Staff member:
A professional who practices medicine, dentistry, and other independent practitioners.

Accreditation Overview

This chapter aims to set the rules and requirements to obtain GAHAR accreditation for the hospital which includes, but not limited to, the following:

1. Compliance with licensure requirements for licensing the hospital as mandated by laws and regulations.
2. The hospital must be operational for at least six months before it can apply for accreditation.
3. Compliance with the GAHAR Safety Requirements for hospitals (herein included), to ensure the safety of the patients/ patients' families, visitors, and staff.
4. Compliance with the requirements of the standards according to Accreditation Decision Rules in this handbook.

A) General rules:

The accredited hospital has to inform GAHAR of any change in the field of services provided (adding a new service, cancelling an existing service, or increasing the volume of an existing service by more than 20%) in writing to the e-mail reg@gahar.gov.eg, at least one month prior to the actual implementation of this change.

- The hospital shall ensure the validity of the documents and data provided at all stages of the accreditation process. If there is evidence that the submitted documents are proven to be inaccurate, the hospital is at risk for rejection of accreditation.
- The accreditation may be withdrawn or at risk of rejection, if there is evidence that the facility has falsified or withheld or intentionally misleading the information submitted to GAHAR.
- The facility is not permitted to use GAHAR's certificate or logo in a misleading manner.
- GAHAR shall inform the facility about the accreditation decision within a period not exceeding 30 working days starting from the date of completion of the survey visit.
- GAHAR has the right to publish the end result of survey visit, accreditation suspension or rejection, according to the requirements.
- The accredited hospital has to communicate all sentinel events to GAHAR within 48 hours of the event or becoming aware of the event via email notification using the following link: Sentinel.Event@gahar.gov.eg. The root cause analysis shall be submitted no later than 45 days starting from the date of the occurrence or its notification with the appropriate corrective plan to prevent/reduce its recurrence according to the nature of the event, (Refer to standard no. QPI.11 for more information).

B) Compliance with current relevant laws, regulations, licensures requirements, and their updates.

C) Accreditation may be suspended (for a period not exceeding 6 months) if:

- The hospital fails to pass unannounced survey,
- The hospital data in the application form does not match its status upon evaluation visit.
- Sentinel events related to the safety of patients, healthcare providers or visitors that has been reported to GAHAR while root cause analysis with the appropriate corrective plan not submitted within 45 days starting from the date of the occurrence or its notification.
- The GAHAR has not been notified of any changes in the scope of services provided (e.g. adding a new service, cancelling an existing service, or increasing the volume of an existing service by more than 20%) within at least one month before the actual implementation of this change.

D) Accreditation may be withdrawn or at risk of rejection if:

- The facility fails to pass follow up surveys in case of conditioned accreditation.

- GAHAR team discover any falsification, withhold or intentionally misleading the information submitted during or after the survey visit, or it is proven that the attached and submitted documents are inaccurate.
- The facility prevents GAHAR regulatory team/inspectors from doing their duties, such as refusal or preventing them from reviewing documents and data related to the scope of their duties.
- The facility refuses to meet the auditors' team or GAHAR surveyors in the announced / unannounced evaluation visits.
- A legal document issued by an administrative agency or Supreme Court rules against the facility either by permanent or temporary closure.
- Moving the facility from its actual place mentioned in the application form, or when the facility is demolished, reconstructed, or rebuilt without any pre notification to GAHAR.
- Exceeding the period prescribed for suspension of accreditation without correcting the reasons for this suspension.

How to apply for a GAHAR survey?

A hospital, seeking GAHAR accreditation begins by:

- Log in to the online platform (Portal) of the General Authority for Health Accreditation and Regulation to register the data of the hospital, via the following link <https://eportal.gahar.gov.eg>.
- Create a new account.
- Choose the type of service, type of facility, and user's data.
- Complete the basic data of the application (the electronic registration application).
- Complete the contact information; the applicant's data; and the healthcare facility data and upload the required documents.
- Print the application request, fill in the declaration, and get it sealed with the facility's seal, re-upload, and click on "Issue application".
- You can browse the system anytime to follow up the status of the request and implement the required requests of GAHAR.
- GAHAR will determine the survey financial fees, and bank account details will be shared.
- The Hospital will make the payment to the central bank of Egypt on the bank account, and it will send to receipt back via email.
- An appointment for the survey visit will be determined for the Hospital.
- GAHAR's Surveyors team will evaluate your hospital, according to the GAHAR handbook for Hospital accreditation standards.
- The survey report is submitted to the accreditation committee to review and decide based on decision rules.
- The Hospital is notified of the decision of the accreditation committee. The hospital has 15 days to submit an appeal. If no appeal is submitted, the chairman of GAHAR approves the decision, and a final certificate is issued.

Look back period

- Surveyors are required to review standards requirements and evaluate organization compliance with them over a lookback period.
- Look back period: It is the period before the survey visit during which any hospital, is obliged to comply with the GAHAR accreditation standards. Failure to comply with this rule affects the accreditation decision.
- Look back period varies from one hospital, to another, depending on the hospital 's accreditation status.
- A hospital, seeking accreditation will:
 - Comply with the GAHAR Handbook for Hospital Accreditation Standards as applicable for at least **four months** before the actual accreditation survey visit.
- A hospital, seeking re-accreditation:
 - For GAHAR-accredited hospitals, compliance with the GAHAR Handbook for Hospitals Accreditation Standards from receiving the approval of the previous accreditation till the next accreditation survey visit.

Scoring Guide

During the survey visit, each standard is scored for evidence of compliance (EOC).

These are mathematical rules that depend on the summation and percentage calculation of scores of each applicable EOC as follows:

- **Met** when the hospital, shows 80% or more compliance with requirements during the required lookback period with a total score of 2.
- **Partially met** when the hospital, shows less than 80% but more than or equal to 50% compliance with requirements during the required lookback period with a total score of 1.
- **Not met** when the hospital, shows less than 50% compliance with requirements during the required lookback period with a total score of 0.
- **Not applicable** when the surveyor determines that, the standard requirements are out of the organization's scope (the score is deleted from the numerator and denominator).
- While most EOCs are independent, stand-alone units of measurement that represent the structure, process, and/or outcome, few EOCs are dependent on each other. Dependence means that compliance with one EOC cannot be achieved (or scored) without ensuring compliance with other EOCs.

Scoring of each standard

- **Met:** when the average score of the applicable EOCs of this standard is 80% or more.
- **Partially met** when the average score of the applicable EOCs of this standard is less than 80% or not less than 50%.
- **Not met** when the average score of the applicable EOCs of this standard is less than 50%.

Scoring of each chapter

Each chapter is scored after calculating the average score of all applicable standards in this chapter.

Accreditation Decision Rules

A Hospital can achieve accreditation by demonstrating compliance with certain accreditation decision rules. These rules mandate achieving certain scores on a standard level, chapter level, and overall level as the accreditation decision is composed of four decisions.

1st Decision: Status of Accreditation for a hospital, (3 years).

- Overall compliance of 80% and more, and
- Each chapter should score not less than 70%, and
- Only one whole standard is scored as not met, and
- No single not met GSR standard.

2nd Decision: Status of Conditioned Accreditation for a hospital, (2 years).

- Overall compliance of 70% to less than 80%, or
- Each chapter should score not less than 60%, or
- Up to one standard not met per chapter, and
- No single not met GSR standard.

3rd Decision: Status of Conditioned Accreditation for a hospital, (1 year).

- Overall compliance of 60% to less than 70%, or
- Each chapter should score not less than 50%, or
- Up to two standards not met per chapter, and
- No single not met GSR standard.

4th Decision: Rejection of Accreditation

- Overall compliance of less than 60%, or
- One chapter scored less than 50%, or
- More than two standards not met per chapter, or
- Not met GSR standard.

Hospitals having status of accreditation or conditioned accreditation with elements of noncompliance are requested to:

- Submit a corrective action plan for unmet EOCs and standards within 90 days for 1st decision, 60 days for 2nd decision, and 30 days for 3rd decision to the email reg@gahar.gov.eg.
- Apply and pass the accreditation survey in 2 years for 2nd Decision and 1 year for 3rd Decision.

Accreditation is valid for 3 years. Accreditation may be suspended or withdrawn if:

- The Hospital fails to pass follow-up surveys in case of conditioned accreditation.
- The Hospital fails to submit corrective action plans in case of the presence of not met EOC(s).
- The Hospital fails to pass the unannounced survey.
- The Hospital fails to comply with GAHAR circulars when applicable.

Acknowledgments

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Acronyms

Acronym	Definition
ACEP	American College of Emergency Physicians
ACT	Access, Continuity, and Transition of Care
AIDS	Acquired immunodeficiency syndrome
AIIR	Airborne infection isolation room
ALS	Advanced life support
AMA	Against medical advice
APIC	Association for Professionals in Infection Control and Epidemiology
ASP	Antimicrobial stewardship program
ATH	Academic and Teaching Hospitals
BPMH	Best possible medication history
CAI	Community Assessment and Involvement
CAUTI	Catheter-associated urinary tract infections
CBC	Complete blood count
CBT	Cognitive-behavioral therapy
CCTV	Closed-circuit television
CCU	Coronary care unit
CDC	Centers for Disease Control and Prevention
CLABSI	Central line-associated bloodstream infections
COPD	Chronic obstructive pulmonary disease
CS	Cesarean section
CT	Computed Tomography
CTG	Cardiotocography
DAMA	Discharged against medical advice
DAS	Diagnostic and Ancillary Services.
DBT	Dialectical behavior therapy
DDD	Defined daily doses
DOT	Days of therapy
DTC	Drug and Therapeutic Committee
ECG	Electrocardiogram
ECT	Electroconvulsive therapy
EEG	Electroencephalogram
EFS	Environmental and Facility Safety
EMG	Electromyography
EMRO	WHO Regional Office for the Eastern Mediterranean
ER	Emergency room
ESKD	End-stage kidney disease
FMEA	Failure Mode and Effects Analysis
GPEI	Global Polio Eradication Initiative
HAIS	Healthcare-associated infections
HEPA	High-efficiency particulate air
HIS	Health information system
IAEA	International Atomic Energy Agency
ICD	International Classification of Diseases
ICHI	International Classification of Health Interventions
ICRA	Infection control risk assessment
ICU	Intensive care unit
IFIC	International Federation of Infection Control

Acronym	Definition
IPC	Infection prevention and control
ISMP	Institute of Safe Medication Practice
ISMP	Institute for Safe Medication Practices
iSoBAR	Identify (i), Situation (S), Observations (o), Background (B), Agreed Plan (A), and Readback (R)
IV	Intravenous
LAMA	Leaving against medical advice
LASA	Look-alike sound-alike
MAT	Medication-assisted treatment
MDROs	Multi-drug resistant organisms
MMS	Medication Management and Safety
MRI	Magnetic resonance imaging
MRP	Most Responsible Physician
MRS	Magnetic resonance spectroscopy
NICU	Neonatal intensive care unit
OCT	Optical coherence tomography
OGM	Organization Governance and Management
OPPE	Ongoing professional practice evaluation
OR	Operation Room
OR	Operation room
OTC	Over-the-counter
PASS	Pull, Aim, Squeeze and Sweep
PCC	Patient-centeredness culture
PCRA	Pre-construction risk assessment
PDCA	Plan-Do-Check-Act
PE	Protective environment
PEST	Political, economic, social, and technological
PET CT	Positron emission tomography-computed tomography
PHI	Protected health information
PICU	Pediatric intensive care unit
POCT	Point-of-Care Testing
POE	Physician order entry
PPE	Personal protective equipment
PRN	As needed (pro re nata)
PSA	Procedural sedation and analgesia
PTC	Pharmacy and Therapeutic Committee
QC	Quality control
QPI	Quality and Performance Improvement
RACE	Rescue, Alarm, Confine, Extinguish/Evacuate
RBC	Red blood corpuscle
RCA	Root cause analysis
REC	Research ethics committee
RFID	Radiofrequency identification
RH	Rhesus factor
SAS	Surgery, Anesthesia, and Sedation
SBAR	Situation-Background-Assessment-Recommendation
SCC	Safe Childbirth Checklist
SDS	Safety data sheet
SMART	Specific, Measurable, Achievable, Relevant, and Time-Bound
SSI	Surgical site infection

Acronym	Definition
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TAT	Turnaround time
TLD	Thermos-luminescent dosimeter
UNICEF	United Nations International Children's Emergency Fund
VAP	Ventilator-associated pneumonia
VEN	Vital/essential/nonessential analysis
VTE	Venous thromboembolism
WFM	Workforce Management
WHO	World Health Organization

SECTION 1

ACCREDITATION PREREQUISITES AND CONDITIONS

Section 1: Accreditation Prerequisites and Conditions

Section Intent:

This chapter is applicable during the accreditation process and aims to provide a clear ethical framework that a hospital must follow in order to comply with the GAHAR survey process. Scores of these standards are always met in order to continue the survey process. One partially met or not met evidence of compliance is to be dealt with on the GAHAR accreditation committee level and may result in denial or suspension of accreditation.

APC Summary of Changes

Summary of Changes Chapter 1

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
APC.01 KW: Accurate and complete information	APC.03 KW: Accurate and complete information	1) Modified EOCs: <ul style="list-style-type: none"> EOC.02: The hospital reports accurate and complete information to GAHAR in between accreditation visits). EOC.03 The hospital reports within 30 days any structural changes in the hospital'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).
APC.02 KW: Professional standards during surveys	APC.05 KW: Professional standards during surveys	1. Modified EOCs: <ul style="list-style-type: none"> (EOC.01: The hospital maintains the values mentioned from (a) to (e) in the intent during the survey process). (EOC.02: Before survey, the hospital reports any conflict of interest to GAHAR with evidence). 2. Added a new EOC: <ul style="list-style-type: none"> (EOC.05: The accredited hospital can use GAHAR accreditation seal according GAHAR's rules).
APC.03 KW: Sustaining compliance with accreditation standards	APC.01 KW: sustaining registration requirements	1) Modified standard statement: <ul style="list-style-type: none"> (The GAHAR accredited hospital ensures continuous compliance with the standards). 2) Modified EOCs: <ul style="list-style-type: none"> (EOC.01, & EOC.02). 3) Updated EOC <ul style="list-style-type: none"> (EOC.04) by merging two EOCs (EOC.04 and EOC.05) in Hospital edition 2021.

Transparent and ethical relationships

APC.01 The hospital 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 hospital is accredited, it lies under GAHAR's scope to be informed of any changes in the hospital and any reports from external evaluators. Hospitals 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 hospital of what data and/or information are required and the period for submission. The hospital is expected to provide timely, accurate, and complete information to GAHAR regarding its structure, hospital scope of work, building, governance, licenses, and evaluation reports by external evaluators. GAHAR requires each hospital 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 hospital reports accurate and complete information to GAHAR during the accreditation process.
2. The hospital reports accurate and complete information to GAHAR in between accreditation visits.
3. The hospital reports within 30 days any structural changes in the hospital'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 hospital 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 Hospital Director, QPI.11 Sentinel events

APC.02 The hospital 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 credibility, professionalism, quality of service, and confidence. The hospital is expected to maintain professional standards in dealing with surveyors. The hospital is expected to report to GAHAR if there is a conflict of interest between a surveyor and the homecare 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 hospital maintains the values mentioned from a) to e) in the intent during the survey process.
2. Before the survey, the hospital reports any conflict of interest to GAHAR with evidence.
3. During surveys, the hospital ensures that the environment does not pose any safety or security risks to surveyors.
4. During the survey, the hospital avoids media or social media releases without GAHAR's approval.
5. The accredited hospital can use the GAHAR accreditation seal according to GAHAR's rules.

Related standards:

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

Sustaining compliance with accreditation standards

APC.03 The GAHAR accredited hospital 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 hospital aiming to unroll in the Universal Health Insurance system. When a hospital 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 hospital'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 hospitals' corrective actions taken in response to GAHAR feedback reports during accreditation period.

Evidence of compliance:

1. The hospital establishes a process for periodic assessment of compliance with accreditation standards.
2. The hospital acts on all feedback and reports received from GAHAR during the accreditation period.
3. The hospital reacts to all GAHAR requirements and reports in a timely manner.
4. The hospital 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



SECTION 2

PATIENT-CENTERED STANDARDS

Section 2: Patient-Centered Standards

Patient-centered care represents a paradigm shift in how patients, healthcare professionals, and other participants think about the processes of treatment and healing. It is defined by the Institute of Medicine as the act of providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. The rise of patient-centered care makes way for a healthcare system designed to optimize the agency and comfort of the most important and vulnerable people in the equation: patients, their families, and their communities.

Over the past two decades, patient-centered care has become internationally recognized as a dimension of the broader concept of high-quality healthcare. In 2001, the semiannual US Institute of Medicine's (IOM), *Crossing the Quality Chasm: A New Health System for the 21st century*, defined good-quality care as safe, effective, patient-centered, timely, efficient, and equitable.

The report sets out several rules to redesign and improve patient-centered care, including ensuring that care is based in continuous, healing relationships; customizing care based on patients' needs and values; ensuring the patient is the source of control; sharing knowledge and information freely; and maintaining transparency.

The IOM report defined four levels that further define quality care and the role of patient-centered care in each level:

1. The experience level refers to an individual patient's experience of their care. Care should be provided in a way that is respectful, informative, and supportive for the participation of patients and families
2. The clinical micro-system level refers to the service, department, or program level of care. Patients and families should participate in the overall design of the service, department, or program.
3. The hospital-level refers to the hospital as a whole. Patients and families should participate as full members of key hospital committees
4. The environment level refers to the regulatory level of the health system. Patients and families can inform local authorities.

According to Charmel and Frampton, the IOM report reinforces patient-centered care not only as a way of creating a more appealing patient experience but also as a fundamental practice for providing high-quality care in the US.

Practically, many Egyptian hospitals could readily put patient's medical record and informed consent policies in place, but many find it hard to actively change the way care is delivered, and struggle to involve patients and learn from their experience. Key strategies from leading patient centered care organizations worldwide include demonstrating committed senior leadership; regular monitoring and reporting of patient feedback data; engaging patients and families as partners; resourcing improvements in care delivery and environment; building staff capacity and a supportive work environment; establishing performance accountability; and supporting a learning organization culture.

Internationally, healthcare services use a range of strategies to promote patient-centered care, including staff development, leadership, collecting and reporting patient feedback, redesigning and co-designing service delivery, implementing patient rights bills, and engaging patients and families as partners in improving care.

There are Eight Principles of Patient-Centered Care as defined by Picker's Institute:



1) Patients' Preferences

At every step, patients should be given the needed information to make thoughtful decisions about their care. Those preferences should always be considered when determining the best course of action for that patient. The expertise and authority of healthcare professionals should complement and enhance the patient perspective. Assessment and care should be in a way that maintains patients' dignity and demonstrates sensitivity to their cultural values healthcare professionals need to focus on the person's quality of life, which may be affected by their illness and treatment. Everyone involved is always on the same team, working toward the same goal.

2) Emotional Support

Challenges of treating and healing the body can also take their toll on the mind and the heart. Practicing patient-centered care means recognizing the patient as a whole person, having a multi-dimensional human experience, eager for knowledge and human connection, who may need extra, specialized help in keeping up the spirit of optimism. It helps to alleviate fear and anxiety the person may be experiencing with respect to their health statute (physical status, treatment, and prognosis), the impact of their illness on themselves and others (family, caregivers, etc.), and the financial impacts of their illness.

3) Physical Comfort

Patients shall summon the courage to face circumstances that are scary, painful, lonely, and difficult. Strong pain relief and a soft pillow can go a long way. Healthcare professionals should work to ensure that the details of patients' environments are working for them, rather than against them. Patients should remain as safe and comfortable as possible through difficult straits, surrounded by people equipped to care for them.

4) Information and Education

Providing complete information to patients regarding their clinical status, progress, and prognosis; the process of care; and information to help ensure their autonomy and their ability to self-manage and to promote their health. When patients are fully informed, given the trust and respect that comes with sharing all relevant facts, they will feel more empowered to take responsibility for the elements of their care that are within their control.

5) Continuity and Transition

A transition from one phase of care to the next should be as seamless as possible. Patients should be well informed about what to expect. Treatment regimens, especially medication regimens, should be clearly defined and understood. And everyone involved should be able to plan and understand what warning signs (and positive indicators) to look out for.

6) Coordination of Care

Every aspect of care depends on every other aspect working as efficiently and effectively as possible. Treatment and patient experience shall be considered as an integrated whole, with different moving parts working in concert to reduce feelings of fear and vulnerability. Healthcare professionals shall cooperate in the interest of the patient's overall wellbeing.

7) Access to Care

To the extent that it is possible, patients should have access to all the care they need, when they need it, in a manner that's convenient and doesn't inflict too much stress. It should be simple to schedule appointments, stick to medication regimens, and practice self-care.

8) Involvement of Family and Friends

Patient-centered care encourages keeping patients involved and integrated with their families, their communities, and their everyday lives by:

- Accommodating the individuals who provide the person with support during care.
- Respecting the role of the person's advocate in decision making.

Supporting family members and friends as caregivers and recognizing their needs.

GAHAR Safety Requirements

Chapter intent:

Patient safety, the reduction and mitigation of unsafe acts within the healthcare system, stands as an unwavering pillar of quality healthcare delivery. The intricate interaction between human factors, systems, and technology within healthcare settings creates a landscape prone to errors, some of which can have severe consequences. Although safeguards such as alarms, standardized procedures, and skilled professionals are in place, the inherent weaknesses in these layers of protection demand a continuous commitment to improvement. The focus on patient safety began to gain significant traction in the late 1990s, sparking a transformation in how healthcare organizations approach patient care. A culture of safety has since emerged, highlighting the importance of open communication, error reporting, and learning from mistakes. This change in mindset has fostered a more proactive and systematic approach to harm prevention. By setting clear expectations and conducting regular evaluations, accreditation bodies promote a culture of safety and accountability. Developing robust safety requirements for accreditation is essential in ensuring that patient safety remains a top priority across healthcare settings. To create effective safety requirements, a comprehensive understanding of the most critical areas of risk is necessary. Medication safety, infection prevention, communication, and patient identification are among the high-priority domains. These requirements should be grounded in evidence-based practices to ensure their effectiveness. As part of the GAHAR accreditation process, Hospitals have to show commitment to patient safety. This requires compliance with each of the GAHAR Safety Requirements (GSRs). During surveys, surveyors evaluate that safe and efficient implementation of each of the GSRs is maintained in all relevant practices. The application of the standards should be according to the applicable laws and regulations.

Chapter purpose:

- 1) **Provide** a comprehensive overview of GAHAR Safety Requirements.
- 2) **Outline** the essential components of an effective patient safety program.
- 3) **Support** organizational efforts to create a culture of safety.
- 4) **Enhance** patient outcomes by minimizing risks and adverse events.

No standards are scored under this chapter; all GAHAR Safety Requirements will be scored in their corresponding chapters.

Summary of NSR Changes

- NSR (National Safety Requirements) – **Renamed to be** – GSR (GAHAR Safety Requirements)
- Added a new GSR (**CSS.05 GSR.11 Cardiopulmonary resuscitation**)

GAHAR Safety Requirements Keywords

Code		Code in this book
GENERAL PATIENT SAFETY		
GSR.01	patient identification	ACT.03
GSR.02	Verbal and telephone orders	ICD.18
GSR.03	Critical Results	ICD.19
GSR.04	Handover Communication.	ACT.08
GSR.05	Fall assessment and prevention	ICD.10
GSR.06	Pressure Ulcers Prevention	ICD.11
GSR.07	Venous Thromboembolism Prophylaxis	ICD.12
GSR.08	Critical Alarms	CSS.02
GSR.09	Catheter and tube misconnections	CSS.03
GSR.10	Recognition and response to clinical deterioration	ICD.22
GSR.11	Cardiopulmonary resuscitation	CSS.05
DIAGNOSTIC AND ANCILLARY SERVICES		
GSR.12	Radiation Safety Program	DAS.09
GSR.13	Laboratory Safety Program	DAS.23
SURGICAL AND INVASIVE PROCEDURAL SAFETY		
GSR.14	Surgical Site Marking	SAS.05
GSR.15	Pre-operative Checklist	SAS.06
GSR.16	Time-out/ sing out	SAS.07
GSR.17	Instrument Retention Prevention	SAS.09
MEDICATION MANAGEMENT AND SAFETY		
GSR.18	Medication Reconciliation, best possible medication history (BPMH)	MMS.10
GSR.19	Medication storage and labelling	MMS.04
GSR.20	High-alert medications and concentrated electrolytes	MMS.06
GSR.21	Look-alike and Sound like medications.	MMS.07
INFECTION PREVENTION AND CONTROL		
GSR.22	Hand Hygiene	IPC.04
ENVIRONMENTAL AND FACILITY SAFETY		
GSR.23	Fire and smoke safety	EFS.03
GSR.24	Fire drills	EFS.04
GSR.25	Hazardous materials safety	EFS.06
GSR.26	Safety Management Plan	EFS.07
GSR.27	Medical Equipment Plan	EFS.10
GSR.28	Utilities Management Plan	EFS.11
INFORMATION MANAGEMENT AND TECHNOLOGY		
GSR.29	Abbreviations	IMT.04

Patient-Centeredness Culture

Chapter intent:

Patient-centered care is a transformative healthcare approach prioritizes the patient in all medical decisions and practices. Unlike traditional models that focus on the disease or the healthcare provider's expertise, patient-centered care emphasizes the patient's needs, preferences, and values, recognizing them as active participants in their care rather than passive recipients.

Developing a patient-centered culture in hospitals requires a comprehensive approach that engages all levels of the organization. This involves training healthcare professionals in effective communication and interpersonal skills, developing care protocols that prioritize patient preferences, and fostering a culture that respects patient autonomy.

Healthcare providers must understand and honor each patient's unique needs, preferences, and values, including cultural, spiritual, and personal factors that influence their decisions and well-being. Patients should be fully informed about their health status, treatment options, and potential outcomes. Transparent communication is crucial for enabling patients to make informed decisions about their care.

Hospitals can further enhance patient-centered care by improving the physical care environment. Creating a welcoming and comfortable atmosphere, offering private rooms, flexible visiting hours, and spaces for family members can significantly improve a patient's experience and recovery. By fostering respectful communication, involving patients and their families in the care process, and coordinating care across multiple disciplines, hospitals can enhance patient satisfaction, improve health outcomes, and elevate overall care quality.

During the GAHAR Survey, surveyors will evaluate how hospitals define and sustain their patient-centered culture. This assessment will involve reviewing relevant documents, observing the implementation of direct patient care during patient tracers, and interviewing staff. Additionally, this topic may be discussed during the leadership interview session.

Chapter purpose:

- 1) To provide strategies for healthcare leaders and staff to develop, implement, and sustain a patient-centered culture.
- 2) To outline the fundamental rights and responsibilities of patients.
- 3) To emphasize the role of a patient-centered culture in increasing patient satisfaction and engagement.
- 4) To illustrate how fostering a patient-centered culture leads to improved care quality and patient outcomes.

PCC Chapter Summary of Changes*Summary of Changes Chapter 2*

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
PCC.01 KW: Multidisciplinary patient-centeredness	PCC.02 KW: Interdisciplinary patient-centeredness PCC.03 KW: Patient centeredness support	1) Updated standard (PCC.01) by merging two standards (PCC.02 and PCC.03) in Hospital edition 2021.
PCC.02 KW: Patient and family rights	PCC.04 KW: Patient and family rights	2) Modified EOC: (EOC.01 : The hospital has an approved policy guiding the process of defining patient and family rights, including items mentioned in the intent from a) through j). 3) Rephrasing of EOCs: <ul style="list-style-type: none"> • (EOC.03: Patients' rights are posted and visible to patients, families, and staff). • (EOC.05: Patients are informed of their rights in a manner they can understand).
PCC.03 KW: Patient and family responsibilities	PCC.05 KW: Patient and family responsibilities PCC.06 KW: Reporting violations	1) Updated standard (PCC.03) by merging two standards (PCC.05 and PCC.06) in Hospital edition 2021.
PCC.04 KW: Admission consent	PCC.07 KW: Admission consent	1) Rephrasing of EOC: (EOC.02 : The patient's or legal representative's approval and consent to being hospitalized is recorded in the patient record).
PCC.05 KW: Communicate with the healthcare team.	PCC.08 KW: Meeting the healthcare team	1) Rephrasing of standard statement to be: (Patients and families can communicate with healthcare professionals, request information, and ask questions). 2) Updated EOC (EOC.02) by merging two EOCs (EOC.02 and EOC.03) in Hospital edition 2021. 3) Added a new EOC: (EOC.03 : Patients and their families are educated about their rights to ask questions, seek information, and actively participate in their care).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		4) Rephrasing of EOC: (EOC.04 : Patient engagement tools are used to encourage patients to pose questions).
PCC.06 KW: Health education materials	PCC.09 KW: Patient and family education materials	1) Rephrasing of standard statement to be: (Health education materials are available). 2) Rephrasing of EOCs: (EOC.02, EOC.03, EOC.04 and EOC.05).
PCC.07 KW: Patient and family education process	PCC.10 KW: Patient and family education process	1) Modified EOC: (EOC.01 : The hospital has an approved policy guiding the process of patient and family education that includes at least the points mentioned in the intent from a) through d).
PCC.08 KW: Informed consent	PCC.11 KW: Informed consent	1) Rephrasing of Standard statement to be: (The hospital has a defined process to obtain informed consent for certain medical processes.) 2) Modified EOCs: <ul style="list-style-type: none"> • (EOC.02 :Informed consent is obtained in a manner and language that the patient understands and does not contain abbreviations.) • (EOC.03: The responsible physician obtaining the informed consent signs the form with the patient).
PCC.09 KW: Informed consent validity	PCC.12 KW: Informed consent validity	No change.
PCC.10 KW: Informed refusal	PCC.13 KW: Informed refusal	1) Added a new EOC: (EOC.05 : The hospital monitors the reported data on informed refusal and takes actions to control or improve the process as appropriate).
PCC.11 KW: Comfortable stay	PCC.15 KW: Waiting spaces PCC.16 KW: Comfortable stay	2) Updated standard (PCC.11) by merging two standards (PPC.15 and PCC.16) in Hospital edition 2021.
PCC.12 KW: Patient's needs	PCC.17 KW: Patient's needs	1) Rephrasing of standard statement to be: (The hospital identifies and addresses patient's emotional, religious, spiritual needs, and other preferences). 2) Modified EOCs:

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<ul style="list-style-type: none"> • (EOC.01: Healthcare providers identify patients' emotional, religious, and spiritual needs). • (EOC.04: Cleaning, food, and other services identify patient and family preferences) • Added a new EOC: (EOC.02: Patient needs and preferences are documented in the patient's medical record). <p>3) Rephrasing of EOC:(EOC.05 Services' schedules are modified in response to patient preferences).</p>
PCC.13 KW: Patient's dignity, privacy, and confidentiality	PCC.18 KW: Patient's dignity, privacy, and confidentiality	1. No change.
PCC.14 KW: Patient's belongings	PCC.19 KW: Patient's belongings	<p>1) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.04 The patient's belongings are protected and recorded according to the policy). • (EOC.05 Lost and found items are recorded, protected, and returned when possible).
PCC.15 KW: Patient and family feedback	PCC.20 KW: Patient and family feedback	<p>1) Rephrasing of EOCs:</p> <ul style="list-style-type: none"> • (EOC.02 Feedbacks from patients and families is received, analysed, and interpreted). • (EOC.03The interpreted feedbacks is shared with concerned staff members). <p>2) Modified EOC: (EOC.04 The hospital monitors the reported data on patients' and families' feedback and takes actions to control or improve the process as appropriate.</p>
PCC.16 KW: Complaints and suggestions	PCC.21 KW: Complaints and suggestions	<p>1) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy guiding the process of managing patients' complaints and suggestions as mentioned in the intent from a) through e). • (EOC.04: Complaints and suggestions are investigated, analyzed by the hospital. and resolved in an approved timeframe). <p>2) Added a new EOC: (EOC.02: Staff is aware of complaints and suggestion policy.</p>

Planning and protecting the patient-centeredness culture

PCC.01 Patient-centered culture is developed and supported by the hospital staff and leaders.

Patient-centeredness

Keywords:

Multidisciplinary patient-centeredness

Intent:

A patient-centered culture is a healthcare philosophy that prioritizes the needs, preferences, and values of patients throughout their medical journey. It emphasizes collaboration, communication, and shared decision-making between healthcare providers and patients.

Patient-centeredness initiatives refer to efforts undertaken within healthcare organizations to prioritize the needs, preferences, and experiences of patients in the delivery of care. These initiatives are designed to shift the focus of healthcare delivery from a provider-centric model to one that revolves around the individual patient.

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

The hospital shall establish a multidisciplinary committee to plan, assist, and oversee the implementation and maintenance of a patient-centered culture.

Active membership of this committee includes at least patients and family members (could be a patient who visits the hospital frequently or for a long period of time), a mix of junior administrative and management staff members, and a combination of clinical and non-clinical.

The committee has defined responsibilities that include 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) Identify potential obstacles and resistance.
- e) Work to remove these obstacles and ease down resistance.

Survey process guide:

- GAHAR surveyor may interview hospital 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 hospital patient-centered culture committee.

Evidence of compliance:

1. The hospital has a multidisciplinary committee with defined responsibility that addresses items from a) to e) in the intent.
2. The committee meets at least quarterly, and minutes are recorded.
3. Staff members are oriented on a patient-centeredness culture.
4. Hospital leadership takes action to encourage staff participation in patient-centeredness initiatives.
5. Patient-centred care initiatives are evaluated, and lessons are learned to improve patient-centred care delivery.

Related standards:

PCC.02 Patient and family rights, PCC.05 Communicate with the healthcare team, PCC.08 Informed consent, PCC.15 Patient and family feedback, OGM.04 Hospital Director

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

Patient-centeredness

Keywords:

Patient and family rights

Intent:

It is crucial for patients to understand and effectively exercise their rights. When patients lack this understanding, the hospital is committed to helping them gain the necessary knowledge. Additionally, the hospital ensures its staff is well-guided in their responsibility to safeguard the rights of patients and their families.

Patient and family rights shall be defined according to laws and regulations, as well as the ethical code of healthcare professionals' syndicates.

The hospital shall develop and implement a policy and procedures that ensure all staff members are informed about and appropriately address patient and family rights issues during their interactions with patients throughout the hospital. This policy shall address at least the following:

- a) Patient and family's right to access care if provided by the hospital.
- b) Patient and family's right to know the name of the treating, supervising, and/or responsible medical staff member.
- c) Patient and family rights to care that respects the patient's personal values and beliefs.
- d) Patient and family rights to be informed and participate in making decisions related to their care.
- e) Patient and family rights to refuse care and discontinue treatment.
- f) Patient and family rights to security, personal privacy, confidentiality, and dignity.
- g) Patient and family rights to have pain assessed and treated.
- h) Patient and family rights to make a complaint or suggestion without fear of retribution.
- i) Patient and family rights to know the price of services and procedures.
- j) Patient and family rights to seek a second opinion either internally or externally.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding patient and family rights.
- GAHAR surveyor may interview staff members to ensure their awareness of the hospital policy.
- GAHAR surveyor may observe that patient rights statements are visibly displayed in the hospital.
- GAHAR surveyor may observe how patients receive information about their rights.
- GAHAR surveyor may observe conditions under which patient rights are protected.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of defining patient and family rights, including items mentioned in the intent from a) through j).
2. All staff members are aware of patients' and families' rights.
3. Patients' rights are posted and visible to patients, families, and staff.
4. Patient and family rights are protected in all areas and at all times.
5. Patients are informed of their rights in a manner they can understand.

Related standards:

PCC.10 Informed refusal, PCC.01 Multidisciplinary patient-centeredness, PCC.04 Admission consent, PCC.13 Patient's dignity, privacy, and confidentiality, PCC.08 Informed consent, ACT.01 Granting access (before patient's registration), ICD.15 Plan of care, OGM.12 Billing System, PCC.16 Complaints and suggestions, ACT.15 Discharge summary, ICD.01 Uniform care.

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 assume responsibilities related to the care process. If, for any reason, a patient or family does not understand their responsibilities, the hospital is committed to helping him/her gain relevant knowledge. The inability to assume these responsibilities might affect the care or management processes of the patients themselves, their families, other patients, or staff members.

The hospital is responsible for making the patients' responsibilities visible to patients and staff members at all times.

The hospital shall develop and implement a policy and procedures to ensure that patients are aware of their responsibilities.

The policy addresses at least the following:

- a) Patients and their families are responsible for providing clear and accurate information on the disease/condition's current and past medical history.
- b) Patients and their families are responsible for complying with the hospital's policies and procedures.
- c) Patients and their families are responsible for complying with financial obligations according to laws, regulations, and hospital policy.
- d) Patients and their families are responsible for showing respect to other patients and healthcare professionals.
- e) Patients and their families are responsible for following the recommended treatment plan.

Sustaining a patient-centeredness culture requires continuous monitoring of compliance and identifying opportunities for improvement. Empowered staff members, patients, and families are able to report violations of any patient's or family's rights and responsibilities.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding patient and family responsibilities.
- GAHAR surveyor may interview staff members to ensure their awareness of the hospital policy.
- GAHAR surveyor may observe that patient responsibilities statements are visibly displayed in the hospital.
- GAHAR surveyor may observe how patients receive information about their responsibilities.

Evidence of compliance:

1. The hospital has an approved policy guiding 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 and visible to patients, families, and staff.
4. Patients are informed of their responsibilities in a manner they can understand.
5. Violations against patients' rights and responsibilities are reported and analyzed, and corrective action is taken.

Related standards:

PCC.04 Admission consent, PCC.08 Informed consent, OGM.12 Billing System, ICD.15 Plan of Care, PCC.10 Informed refusal

Empowerment and involvement of patients and their families

PCC.04 Admission consent is obtained from the patient or a legal representative before hospitalization after discussing the patient's needs and obligations.

Patient-centeredness

Keywords:

Admission consent

Intent:

Admission consent represents a patient's or family's understanding and approval of the hospitalization process and its consequences. These consequences may include potential costs, hazards, and obligations that the patient may acquire during hospitalization. The hospital shall develop and implement a process to give patients and their families information about potential costs and obligations in a language they understand.

A legal representative is an individual or entity authorized by law to act on behalf of another person in legal matters, including making decisions, signing documents, and representing their interests. When neither a patient nor a legal representative can provide hospital admission consent, the situation becomes complex, and healthcare providers need to follow the hospital's established legal and ethical procedures to ensure the patient's best interests are protected.

Survey process guide:

- GAHAR surveyor may observe the process of obtaining admission consent from patients before hospitalization and the used templates or forms with responsible staff through visiting the hospital admission point, such as the admission office, ER desk, Nurse stations, or others.
- GAHAR surveyor may ensure that patients received information about, potential costs, hazards, and obligations that may acquire during hospitalization.
- GAHAR surveyor may review a sample of patients' medical records for those hospitalized patients to check admission consent completion.

Evidence of compliance:

1. Admission consent is provided in writing in a language that the patient understands.
2. The patient's or legal representative's approval and consent to being hospitalized is recorded in the patient record.
3. There is a process to address situations when neither a patient nor a legal representative can give admission consent.
4. Those responsible for obtaining admission consent are able to answer questions pertinent to potential costs and obligations of hospitalization.

Related standards:

ACT.01 Granting access (before patient's registration), PCC.02 Patient and family rights,PCC.03 Patient and family responsibilities,OGM.12 Billing System.

PCC.05 Patients and families can communicate with healthcare professionals, request information, and ask questions.

Patient-centeredness

Keywords:

Communicate with the healthcare team.

Intent:

During all phases of care and especially during visiting hours, patients and their families may have questions about diagnosis, plan of care, expected outcome of care, length of stay, or other questions.

Patients and families are encouraged to ask questions, and systems are in place to capture questions that arise when healthcare professionals are not present to answer them. Patients and families may have access to healthcare professionals during their care journey, whether through in-person consultations, phone lines, secure messaging platforms, or other accessible means of communication, and healthcare professionals should respond to patient and family inquiries and requests for information in a timely manner adhering to established response timeframes (e.g., within 24 hours for non-urgent queries).

Patient engagement tools, such as “Five moments of medication safety” or “Ask me if I washed my hands campaigns,” encourage patients to ask questions.

If the hospital has a feedback mechanism to capture patient and family input on their communication experiences, analyzed data could be used to continuously improve communication processes.

Survey process guide:

- GAHAR surveyor may interview patients or staff members to evaluate the presence and effectiveness of systems for addressing patient and family inquiries and requests.
- GAHAR surveyor may check the availability of patient engagement tools used to encourage patients to pose questions.

Evidence of compliance:

1. A process is in place to allow patients and families to meet or talk to healthcare professionals when needed.
2. Healthcare professionals respond to patient and family inquiries and requests for information in a timely manner, according to the hospital process.
3. Patients and their families are educated about their rights to ask questions, seek information, and actively participate in their care.
4. Patient engagement tools are used to encourage patients to pose questions.

Related standards:

PCC.02 Patient and family rights, PCC.06 Health education materials, ICD.15 Plan of Care, PCC.08 Informed consent.

PCC.06 Health education materials are available.

Patient-centeredness

Keywords:

Health education materials

Intent:

Mass education may take the form of videos, social media posts, brochures, pamphlets, text messages, or other forms. Education materials should be appropriate for the hospital'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. This could include requirements relating to smoking cessation programs, stress management advice, diet and exercise guidance, and substance abuse management.

Hospitals may need to provide mass education of patients and families on certain health topics based on the served community needs. It is important for hospitals to make sure that these materials are available when needed, especially during health campaigns and high-risk procedures. It is also important to ensure that these educational materials are understandable by the target audience and that they may include different languages or pictorial illustrations.

Survey process guide:

- GAHAR surveyor may review a list of all potential topics, places, and/or timings of distributing health education materials.
- GAHAR surveyor may observe the health education materials left for patients in waiting rooms, service desks, nurse stations, and other areas.

Evidence of compliance:

1. The hospital identifies the topics, places, and/or timings for distributing health education materials.
2. Health education materials are readily available at the times and places and for the topics identified by the hospital.
3. Health education materials contain relevant and evidence-based information.
4. Health education materials are appropriate for readers of varying literacy levels.
5. Health education materials are translated into different languages for foreign patient groups, if applicable.

Related standards:

PCC.02 Patient and family rights, PCC.05 Communicate with the healthcare team, CAI.04 Community involvement activities.

PCC.07 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 empowers patients and families to make informed decisions. Multiple disciplines contribute to the process of educating patients and families during care processes.

The Hospital shall develop and implement a policy and procedures to define the process of patient and family education. The policy addresses at least the following:

- a) Identify patient and family 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 condition of the patient.
 - ii. Care plan, expected outcome of care and alternative to the plan of care.
 - iii. Discharge instructions.
- b) Multidisciplinary responsibility of patient and family education process
- c) The method of education is provided according to patient and family values and level of learning, as well as in a language and format that they understand.
- d) Documentation of patient education activities, including information and education provided, how the information and education were delivered (e.g., in writing, verbally, by demonstration, etc.), and confirmation that the patient and/or family understood the information and education provided.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding the patient and family education process.
- GAHAR surveyor may interview staff members to ensure their awareness of patients' and families' education process and recording.
- GAHAR surveyor may review a sample of patients' medical records to check the completion of patient and family education records.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of patient and family education that includes at least the points mentioned in the intent from a) through d).
2. All staff members are aware of patients' and families' education process and recording.
3. Patients receive education relevant to their condition.
4. Patient education activities are recorded in the patient's medical record.

Related standards:

PCC.02 Patient and family rights, PCC.03 Patient and family responsibilities, ICD.15 Plan of Care, ICD.10 Fall assessment and prevention, PCC.08 Informed consent, DAS.04 Pre-examination process, ICD.20 Ordering of blood and blood products, MMS.14 Medication dispensing, distribution system, patient education, and counseling, ICD.12 Venous Thromboembolism Prophylaxis, ICD.11 Pressure Ulcers Prevention

PCC.08 The hospital has a defined process to obtain informed consent for certain medical processes.

Patient-centeredness

Keywords:

Informed consent

Intent:

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

The hospital 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 includes at least the following:

- a) The list of medical processes when informed consent is needed; this list includes:
 - i. Surgery and invasive procedures.
 - ii. Anaesthesia, moderate and deep sedation.
 - iii. Use of blood and donation of blood.
 - iv. High-risk procedures or treatments (including but not limited to electroconvulsive treatment, radiation therapy, and chemotherapy).
 - v. Research.
 - vi. Photographic and promotional activities, for which the consent could be for a specific time or purpose.
- b) The likelihood of success and the risk of not doing the procedure or intervention, as well as the benefits and alternatives to performing that particular medical process.
- c) Certain situations when consent can be given by someone other than the patient, as well as mechanisms for obtaining and recording it according to applicable laws and regulations and approved hospital policies.
- d) Consent forms available in all applicable locations.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the process of obtaining informed patient consent.
- GAHAR surveyor may review the list of medical processes when informed consent is needed.
- GAHAR surveyor may review a sample of patients' medical records to check informed patient consent completion.

- GAHAR surveyor may observe the distribution and availability of informed consent forms by visiting areas where they are most needed, such as the operating room, dental clinic, endoscopy unit, and others.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of informed consent that includes all elements mentioned in the intent from a) through d).
2. Informed consent is obtained in a manner and language that the patient understands and does not contain abbreviations.
3. The responsible physician obtaining the informed consent signs the form with the patient.
4. Informed consent given by someone other than the patient complies with applicable laws and regulations.

Related standards:

PCC.02 Patient and family rights, PCC.07 Patient and family education process, WFM.08 Continuous Education Program

PCC.09 Informed consent validity is defined.

Timeliness

Keywords:

Informed consent validity

Intent:

Informed consent should be valid during the time or procedure it is intended to cover. Sometimes, consents become invalid in instances when:

- a) A patient's health condition changes.
- b) The plan of care changes.
- c) Important additional information arises that will carry different risks and hazards to the patient if they undergo the intended procedure.
- d) A certain time period passes, especially for complex patients and treatments.
- e) The patient's mental status is altered.
- f) The medical staff member who was supposed to perform certain procedure changes.

The hospital should identify these situations when consent is no longer considered valid and the process for obtaining and recording a new one.

Survey process guide:

- GAHAR surveyor may interview the relevant staff members to ensure their awareness of consent validity.

Evidence of compliance:

1. The hospital defines validity requirements for informed consent.
2. All relevant staff members are aware of consent validity.
3. A new consent is obtained when the old consent expires or becomes invalid, as mentioned in elements in the intent from a) to f).
4. A new consent is recorded in the patient's medical record when indicated.

Related standards:

PCC.08 Informed consent, WFM.08 Continuous Education Program, IMT.08 Patient's Medical record Management, ICD.15 Plan of Care.

PCC.10 Patients and families are informed about their rights and responsibilities related to refusing or discontinuing a step(s) in the medical care process.

Patient-centeredness

Keywords:

Informed refusal

Intent:

Refusing or discontinuing medical care against medical advice (AMA) could be for a step(s) or taking the decision to be discharged against medical advice (DAMA), or even leaving emergency services (LAMA).

Patients and families are given enough information, education, and documents about risks when his/her/their choices may result in patient harm. Staff members should also receive education to focus on the strengths and empowerment of patients to make an informed choice/decision.

The hospital shall develop and implement a policy and procedures to inform and educate patients on the risk(s)/benefit(s) when patient choice conflicts with the standards of care. The policy addresses at least the following:

- a) How to inform the patient/family of the patient's current medical condition.
- b) How to inform the patient/family of the consequences of their decision.
- c) How to record patient and/or family refusal of the medical care process step.
- d) Patients are informed about available care and treatment alternatives.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding the process of informed refusal.
- GAHAR surveyor may review a sample of patients' medical records to check the patient's informed refusal form and assess its completion.
- GAHAR surveyor may observe the distribution and availability of informed refusal forms by visiting areas where they are needed the most, such as the emergency room, inpatient wards, and others.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of informed refusal.
2. The informed refusal form contains all required information regarding the intent from a) through d).
3. Informed refusal form is recorded and kept in the patient's medical record.
4. Informed refusal form given by someone other than the patient complies with applicable laws and regulations.
5. The hospital monitors the reported data on informed refusal and takes actions to control or improve the process as appropriate.

Related standards:

PCC.02 Patient and family rights, PCC.03 Patient and family responsibilities, PCC.07 Patient and family education process, IMT.08 Patient's Medical record Management

Ensuring the patient's physical comfort

PCC.11 The hospital's design ensures that patient rooms, waiting areas, and clinics are designed for optimal physical comfort.

Patient-centeredness

Keywords:

Comfortable stay

Intent:

Creating a comfortable environment for patients is essential for fostering a positive outlook upon discharge. According to the American Hospital Association, over 600 studies have linked the hospital environment to patient satisfaction, stress, health outcomes, and overall healthcare quality.

Key factors in the hospital environment include noise levels, patient management, pain management, and communication facilitation. Excessive noise can disrupt sleep and comfort, hindering recovery and limiting communication. Hospital cleanliness is crucial for patient comfort and creating a calm atmosphere.

The hospital ensures a comfortable stay that meets the needs of both patients and their families. Healthy food shall be available for patients and their companions 24 hours a day and seven days a week, this could be through round-the-clock cafeteria, healthy vending machines, or others.

Waiting areas, often a major pain point, can heighten emotions like anxiety, fear, and frustration, especially when combined with uncomfortable seating, lack of basic amenities, and overcrowding. The hospital is dedicated to making waiting spaces comfortable and suitable for patients and their families.

Survey process guide:

- GAHAR surveyor may ensure patient comfort by visiting patients' rooms of multiple economic statuses.
- GAHAR surveyor may ensure comfortable spaces and equipment through visiting waiting areas in outpatient clinics, emergency room, admission office, registration office, cafeteria, or other areas.
- GAHAR surveyor may check toilets and potable water availability through visiting waiting spaces in outpatient clinics, emergency room, admission office, registration office, cafeteria, or other areas.

Evidence of compliance:

1. The physical environment is convenient for a patient's condition, such as space, ventilation, temperature, lighting, noise, and equipment.
2. Waiting spaces are planned to accommodate the expected number of patients and families.
3. Waiting spaces provide access to satisfy basic human needs such as toilets and potable water.
4. Visiting hours are convenient for patients and their families.

Related standards:

PCC.02 Patient and family rights, PCC.13 Patient's dignity, privacy, and confidentiality, EFS.07 Safety Management Plan, EFS.01 Hospital environment and facility safety management, EFS.09 Security plan.

Protecting patient's belongings, privacy, and confidentiality

PCC.12 The hospital identifies and addresses the patient's emotional, religious, spiritual needs and other preferences.

Patient-centeredness

Keywords:

Patient's needs

Intent:

Research has indicated communication during medical interactions can influence patients' emotional experiences and potentially have positive impacts on psychosocial health outcomes. The comprehensive approach to patient care encompasses not only the physical aspects of health but also the emotional and spiritual well-being of individuals.

Hospitals shall provide care that is sensitive to patients' emotional, religious, spiritual, and other personal needs and preferences. Healthcare providers shall receive training in cultural competence, including sensitivity to religious and spiritual beliefs, to facilitate respectful and effective interactions with patients from diverse backgrounds.

Hospitals shall also provide access to support services that cater to patients' emotional, religious, and spiritual needs. These services may include counseling and/or access to religious or spiritual leaders.

Survey process guide:

- 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.
- GAHAR surveyor may review a sample of the patient's medical record to assess documentation of patient needs and preferences.

Evidence of compliance:

1. Healthcare providers identify patients' emotional, religious, and spiritual needs.
2. Patient needs and preferences are documented in the patient's medical record.
3. Plans of care consider emotional, religious, and spiritual needs.
4. Cleaning, food, and other services identify patient and family preferences.
5. Services' schedules are modified in response to patient preferences.

Related standards:

PCC.01 Multidisciplinary patient-centeredness, PCC.02 Patient and family rights, ICD.15 Plan of Care, ICD.13 Patient nutritional needs, PCC.11 Comfortable stay.

PCC.13 Patient's dignity, privacy, and confidentiality are protected during all medical care processes, such as screening, assessments, care, and treatments.

Patient-centeredness

Keywords:

Patient's dignity, privacy, and confidentiality

Intent:

One of the most important human needs is the desire for respect and dignity. The patient has the right to care that is respectful and considerate at all times, in all circumstances, and recognizes the personal worth and self-dignity of the patient. Patient privacy, particularly during clinical interviews, examinations, procedures/treatments, and transport, is important. Patients may desire privacy from other staff members, from other patients, or even from accompanying family members. The hospital must treat the patient's information as confidential and must implement processes to protect such information from leakage, loss, or misuse.

Survey process guide:

- GAHAR surveyors may observe situations, such as patient's examination, procedures, transport to ensure that patient's privacy is maintained.
- GAHAR surveyor may observe that the patient's information confidentiality is maintained.

Evidence of compliance:

1. Patient's privacy is respected for all clinical interviews, examinations, and procedures/treatments.
2. Patient's privacy is respected during patient's transport.
3. Confidentiality of patient information is maintained according to laws and regulations.
4. Patients are allowed to decide who can attend their screening, assessment, or care processes.

Related standards:

PCC.02 Patient and family rights, PCC.11 Comfortable stay, IMT.05 Confidentiality and Security of data and information.

PCC.14 The hospital'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 hospital shall develop and implement a policy and procedures to accept custody of patients' belongings or not. Hospitals may accept custody of the patient's belongings for the patient's best interests if acceptance is not likely to disrupt or compromise hospital operations, patient or employee safety, and if the patient is not capable of being responsible for the belongings and family or designee is unavailable to take custody of the belongings. The hospital policy shall 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 hospital's responsibility for belongings.
- c) Staff who are responsible for managing patient belongings.
- d) The process in place to manage patient's property including, how are the belongings recorded and protected? for how long? how and when patient's property is returned?
- e) How the hospital will manage lost and found situations. The hospital shall define a clear process to follow when items are not returned within a defined timeframe.

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy guiding hospital responsibilities for patient's belongings as mentioned in the intent from a) through e).

2. Responsible staff members are aware of the hospital's policy.
3. Information about the hospital's responsibility for belongings is given to the patient or family, as applicable.
4. The patient's belongings are protected and recorded according to the policy.
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.09 Security plan.

Responsiveness to patients' and families' voices

PCC.15 The hospital improves provided services based on measured patients' and families' feedback.

Patient-centeredness

Keywords:

Patient and family feedback

Intent:

Patient feedback could include concerns, compliments, and formal complaints or through surveys, which may help hospitals to identify ways of improving clinical and non-clinical performance. Ultimately, that translates into better understand the patient's needs, better care, and happier patients. Hospitals can solicit feedback from patients in a variety of ways: phone surveys, written surveys, focus groups, or personal interviews. Many hospitals use written surveys, which tend to be the most cost-effective and reliable approach. The hospital shall develop and implement a policy and procedures to guide the process of managing patient feedback that addresses at least the following:

- a) Measuring feedback for hospitalized patients.
- b) Measuring feedback for ambulatory patients.
- c) Measuring feedback for emergency patients.

The hospital determines whether the process addresses the measurement of patient experience or patient satisfaction. For patient experience, the hospital assesses whether something that should happen in a healthcare setting (such as clear communication with a healthcare professional) actually happened or how often it happened. For patient satisfaction, the hospital measures whether a patient's expectations about a health encounter were met. Two people who receive the exact same care but who have different expectations for how that care is supposed to be delivered can give different satisfaction ratings because of their different expectations. Measuring alone is not enough; hospitals need to analyze and interpret information obtained from measured feedback and identify potential improvement projects.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the process of managing patient and family feedback.
- GAHAR surveyor may interview hospital leaders to ensure the usage of patient and family feedback for performance improvement.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of patient and family feedback measurement as mentioned in the intent from a) through c).
2. Feedback from patients and families is received, analyzed, and interpreted.
3. The interpreted feedback is shared with the concerned staff members.
4. The hospital monitors the reported data on patients' and families' feedback and takes actions to control or improve the process as appropriate.

Related standards:

PCC.01 Multidisciplinary patient-centeredness, PCC.02 Patient and family rights, PCC.05 Communicate with the healthcare team, PCC.16 Complaints and suggestions, QPI.07 Managerial Performance Measures, QPI.12 Sustaining Improvement.

PCC.16 Patients and families are able to make oral or written complaints or suggestions through a defined process.

Patient-centeredness

Keywords:

Complaints and suggestions

Intent:

While hospitals shall be able to proactively measure and use patient's feedback, patients and families may also want to give oral or anonymous complaints or suggestions about their care and to have those complaints or suggestions reviewed and acted upon. The hospital 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. The hospital policy addresses at least the following:

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

Survey process guide:

- The GAHAR surveyor may review the policy of managing patient complaints and suggestions.
- The GAHAR surveyor may assess the process of managing patient suggestions and complaints during tracer activities, leadership interview sessions, or during quality program review sessions.

Evidence of compliance:

1. The hospital 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 policy.
3. The hospital allows the complaining process to be publicly available.
4. Complaints and suggestions are investigated, analyzed by the hospital, and resolved in an approved timeframe.
5. Patients and families receive feedback about their complaints or suggestions within approved timeframes.

Related standards:

PCC.01 Multidisciplinary patient-centeredness, PCC.02 Patient and family rights, PCC.05 Communicate with the healthcare team, PCC.15 Patient and family feedback.

Access, Continuity, and Transition of Care

Chapter intent:

Access is the process by which a patient can start receiving healthcare services. Facilitating access to healthcare is concerned with helping people command appropriate healthcare resources to preserve or improve their health. Access is a complex concept, and at least four aspects require evaluation: Availability, Affordability, Acceptability, and Physical Accessibility.

Continuity of care becomes increasingly important for patients as community ages develop multiple morbidities and complex problems or include more patients who become socially or psychologically vulnerable.

Transitional care refers to the coordination and continuity of healthcare during a movement from one healthcare setting, either to another one or to home, between healthcare professionals and settings as their condition and care needs change during the course of a chronic or acute illness.

WHO presented the global framework for access to care, announcing that all people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient, and acceptable; and all careers are motivated, skilled, and operate in a supportive environment.

Hospitals shall consider all access to services, even on the pre-hospital level, when applicable. Building a Most Responsible Physician (MRP) culture is also important. Establishing organization policies on patient flows and studying flow bottlenecks helps organizations better use available resources and safely handle patient journeys. Effective referral and transfer processes are crucial for seamless patient transitions, ensuring timely and appropriate care. This structured approach helps optimize resources and improve patient outcomes.

During a GAHAR survey, the GAHAR surveyor will assess the smooth flow of patients to/from the hospital and the process and its implementation. In addition, they will interview staff and review documents related to the standards to ensure that equity, effectiveness, and an efficient process are in place.

Chapter purpose:

The main objectives of this chapter are:

1. To ensure hospitals provide and maintain equitable and effective access to patient care services safely and efficiently.
2. To describe the patient's journey from initial access to healthcare services, whether through the emergency room, outpatient department, or registration/admission offices.
3. To ensure that responsibility for the patient's plan of care is assigned throughout the patient's journey.
4. To develop a process that mitigates risks associated with physically transporting patients, ensuring no mishandling or loss of information.
5. To document clear information upon a patient's discharge, transfer, or referral to an external service.

ACT Chapter Summary of Changes

Summary of Changes Chapter 3

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
ACT.01 KW: Granting access (before patient's registration)	ACT.01 KW: Granting access (before patient's registration) ACT.05 KW: Physical access and comfort	Updated standard (ACT.01) by merging two standards (ACT.01 & ACT.05) in Hospital edition 2021.
ACT.02 KW: Registration process	ACT.02 KW: Registration process	<p>1) Modified standard statement: (The hospital has a process in place guiding patient registration and flow pathways).</p> <p>2) Modified EOC: (EOC.01: The hospital has an approved policy guiding hospital registration that addresses all elements mentioned in the intent from a) through c).</p>
ACT.03 KW: Patient identification	ACT.03 KW: Patient identification	<p>1) Modified EOC: (EOC.03: Patient identification is conducted before performing diagnostic procedures, providing treatments, and performing any procedures).</p> <p>2) Updated EOC (EOC.05) by merging two EOCs (EOC.05 and EOC.06) in Hospital edition 2021.</p>
ACT.04 KW: Hospitalization process	ACT.04 KW: Hospitalization process	<p>1) Rephrasing of standard statement to be: (The hospital has a process in place guiding the hospitalization of patients, including those coming from the outpatient area, emergency areas, and other hospitalization routes.).</p> <p>2) Modified EOC: (EOC.01: The hospital has an approved policy and procedure for hospitalization that addresses all elements mentioned in the intent a) through e).</p> <p>3) Modified EOC: (EOC.03: When a patient bed is unavailable, the hospital supports providing care to patients admitted to temporary inpatient locations or boarded in the emergency room).</p> <p>4) Added a new EOC: (EOC.05 Required information is given to the patient and family at the time of admission).</p>

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
ACT.05 KW: Wayfinding signage	ACT.06 KW: Wayfinding signage	1) Rephrasing EOC: (EOC.04 Signs are visible and/or lit during all operating times).
ACT.06 KW: Patient's flow risks	ACT.07 KW: Patient's flow risks	1) Modified standard statement (There is a process in place to manage patient flow through the hospital).
ACT.07 KW Patient's care responsibility	ACT.08 KW: Patient's care responsibility	1) Rephrasing of standard statement to be: (The hospital has a process guiding the assignment of patient care responsibility). 2) Added a new EOC: (EOC.02: The medical staff are aware of the contents of the policy).
ACT.08 KW: Handover communication	ACT.09 KW: Handover communication	1) Added a new EOC: (EOC.03: Handover communication conducted between different shifts and between different levels of care (different departments/ services). 2) Modified EOC: (EOC.04: Handover communications are documented using an established tool or format and are accessible as needed). 3) Updated EOC (EOC.05) by merging two EOCs (EOC.04 and EOC.05) in Hospital edition 2021.
ACT.09 KW: Second opinion	ACT.10 KW: Second opinion	1) Rephrasing of Standard statement to be: (The hospital has a process in place guiding the provision of second opinion).
ACT.10 KW: Consultation process	ACT.11 KW: Consultation process	1) Modified standard statement: (The consultation process is available, and provided based on the patient's needs and within a predefined time frame.) 2) Rephrasing of EOC: (EOC.05 Information exchange between consultation requestor and responder to consultation requests is comprehensive and recorded in the patient's medical record).
ACT.11 KW: Multidisciplinary Management	ACT.12 KW: Multidisciplinary Management	1) Rephrasing of standard statement to be: (Multidisciplinary management process is accessible and provided according to the patient's condition and needs).
ACT.12 KW: Patient's Transportation	ACT.13 KW: Patient's Transportation	3) Rephrasing of standard statement to be: (Transportation of patients is coordinated and provided in an approved timeframe).
ACT.13 KW: Special care units' access	ACT.14 KW: Special care units' access	1) Modified EOC: (EOC.01 The hospital has approved admission and discharge criteria for intensive care and specialized units.).
ACT.14	ACT.15	Updated standard (ACT.14) by merging two

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
KW: Patient's referral, transfer, temporary discharge and discharge.	KW: Patient's flow out (transfer, referral, temporary discharge and discharge). ACT.17 KW: Referral/transfer sheet	standards (ACT.15 and ACT.17) in Hospital edition 2021.
ACT.15 KW: Discharge summary	ACT.16 KW: Discharge summary	1) Rephrasing of EOC: (EOC.01 : Staff members involved in the process of patient discharge are aware of the mechanism to obtain a discharge summary). 2) Added a new EOC: (EOC.04 : A copy of discharge summary is given to the patient).
ACT.16 KW: Telemedicine		1) A new standard

Effective and safe patient flow in the hospital

ACT.01 The hospital grants patients access to its services according to applicable laws and regulations.

Patient-centeredness

Keywords:

Granting access (before patient's registration)

Intent:

Access to healthcare means timely use of personal health services to achieve the best health outcomes. The hospital shall establish a systematic and transparent process for granting patients access to the services provided, promoting efficiency and consistency in the admission process and ultimately enhancing the quality of care provided in the facility.

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.

Implementing pre-set eligibility criteria will facilitate the prioritization of individuals whose needs align with the facility's services. These pre-set criteria need to be available for those responsible for granting access to patients. The hospital will conduct a pre-admission screening to determine if the individual is eligible for admission and if the hospital can meet their care needs.

This screening may involve reviewing medical records, conducting an in-patient assessment, and interviewing the individual and their family. 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.

Accessible infrastructure for patients with special needs should also be considered. This may include handicapped parking, wheelchair-accessible entrances, toilets for disabled patients, walking rails, etc.

The hospital shall develop and implement a policy and procedures to guide the process of granting access. The policy shall address at least the following:

- a) Identifying the hospital-wide scope of service.
- b) How to provide complete information on the care provided and services access the hospital offers.
- c) The process of screening patients to determine that the hospital's scope of services can meet their healthcare needs.
- d) Access through emergency areas is safe and appropriate for patients' conditions.
- e) Access through ambulatory areas includes a clearly defined patient scheduling and queuing process.
- f) Actions to be taken if the patient's needs do not match the facility's scope of service.
- g) Accessibility of hospital services for patients with various types of disabilities.

Survey process guide:

- GAHAR surveyor may review the hospital policy and related documents guiding the process of granting access.
- GAHAR surveyor may observe the process of granting access by visiting the point of first contact in the hospital, 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 concerning available services, operating hours, the cost of each service, and the access path.

Evidence of compliance:

1. The hospital has an approved policy granting access to patients that addresses all elements mentioned in the intent from a) through g).

2. The hospital provides complete information on the available services, including operating hours, types of services, cost of each service (when relevant), and access path.
3. When a patient's healthcare needs do not match the hospital's scope of service, the patient is referred and/or transferred to another healthcare organization or given assistance in locating the service.
4. Hospital services are accessible for patients with various types of disabilities.

Related standards:

PCC.02 Patient and family rights, ACT.02 Registration process, ACT.12 Patient's Transportation, ACT.14 Patient's referral, transfer, temporary discharge, and discharge, CAI.07 Hospital advertisement.

ACT.02 The hospital 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. Usually, it is a complex process that requires a considerable amount of preliminary patient data input, including a collection of patient demographic information such as personal and contact information, patient referral or appointment scheduling, collection of patient health history, and checking of health payer coverage. If handled incorrectly, this series of initial touchpoints can lead to several ongoing issues, including overwhelmed patients who may decide not to pursue their care at a disorganized hospital. The hospital shall develop and implement policies and procedures to guide the registration process. The policy includes at least the following:

- a) Minimum information needed to register the patient.
- b) Coordinating patient flow between necessary hospital services
- c) Minimum information needed 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.

Survey process guide:

- GAHAR surveyor may review the hospital policy and related documents guiding the registration process.
- GAHAR surveyor may interview involved staff members to ensure their awareness of the hospital policy.
- GAHAR surveyor may assess compliance with the hospital policy by visiting the patient registration areas in the hospital, such as service desks, receptions, call centers, registration offices, admission offices, nurse stations, emergency rooms, or outpatient areas.
- 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, especially in life-threatening conditions.

Evidence of compliance:

1. The hospital has an approved policy guiding hospital registration that addresses all elements mentioned in the intent from a) through c).
2. All staff members involved in patient registration and flow pathways are aware of the hospital 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.
4. Patient registration and flow processes are uniform for all patients.

Related standards:

PCC.02 Patient and family rights, ACT.05 Wayfinding signage, ACT.04 Effective hospitalization process, ACT.12 Patient's transportation, EFS.01 Hospital environment and facility safety management, IMT. 08 Patient's Medical record Management.

ACT.03 GSR.01 Accurate patient identification through at least two identifiers to identify the patient and other 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 that may have grave consequences. Using two unique identifiers for each patient is the key to minimizing such preventable errors, which is especially important when administering high-alert medications or performing high-risk or invasive procedures.

The hospital 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 include medications, clinical specimens, blood and blood products, and others.
- d) Method to document identifiers such as wristbands, ID cards, and others.
- e) The prohibited items for patient identification, such as the patient's bed and room numbers, and others.
- f) Special situations when patient identification may not follow the same process, such as for newborn babies, unidentified patients, disasters, and others.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the process of patient identification.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the hospital policy and ensure their usage of at least two unique patient identifiers before procedures such as blood sampling, medications administration...etc.
- GAHAR surveyor may review a sample of medical records to check the presence of the two identifiers mentioned in the policy in each sheet.
- GAHAR surveyor may observe patient identification wristbands with the two unique identifiers and ensure compliance with the patient identification process before procedures or care.
- GAHAR surveyor may observe staff in special areas to check how they conduct patient identification, for example, pediatric or newborn identification at delivery and discharge ...etc.

Evidence of compliance:

1. The hospital 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 hospital policy.
3. Patient identification is conducted before performing diagnostic procedures, providing treatments, and performing any procedures.

4. The patient's identifiers are recorded in the patient's medical record.
5. The hospital monitors the reported data on patients' identification and takes actions to control or improve the process as appropriate.

Related standards:

ACT.14 Patient's referral, transfer, temporary discharge, and discharge, DAS.04 Pre-examination process, DAS.08 Medical imaging results, DAS.15 Specimen reception, tracking and storage, ICD.20 Ordering of blood and blood products, MMS.13 medication preparation area, labeling of medications, IMT. 08 Patient's Medical record Management.

ACT.04 The hospital has a process in place guiding the hospitalization of patients, including those coming from the outpatient area, emergency areas, and other hospitalization routes.

Patient-centeredness

Keywords:

Hospitalization process.

Intent:

Hospital admission involves staying at a hospital for at least one night or more. The hospital shall develop and implement a policy and procedures in order to clarify and simplify the hospitalization process.

The policy addresses at least the following:

- a) Hospitalization procedures of patients, including those coming from the outpatient area, emergency areas, and other hospitalization routes.
- b) The hospital plan for bed, time frame for hospitalization, medical equipment, supplies, and medication to support patient care.
- c) Information to be given to the patient and family at the time of hospitalization.
- d) Management of patients when the bed is not available.
- e) Management of patients whose care needs cannot be met by the hospital, including care at emergency rooms, outpatient clinics, or inpatient services.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the hospitalization process.
- GAHAR surveyor may interview involved staff members to ensure their awareness of the hospital policy.
- GAHAR surveyor may observe the hospitalization process by visiting the hospitalization areas in the hospital such as admission office, nurse stations, emergency rooms, or outpatient areas.
- GAHAR surveyor may observe to check the time interval between the decision to admit the patient and when he actually became on the bed and also to check how the hospital manages the patient's requirements throughout this time.

Evidence of compliance:

1. The hospital has an approved policy and procedure for hospitalization that addresses all elements mentioned in the intent a) through e).
2. All staff members involved in the patient hospitalization process are aware of the policy.
3. When a patient bed is unavailable, the hospital supports providing care to patients admitted to temporary inpatient locations or boarded in the emergency room.
4. When patient care is required during the admission process, the care plan is recorded in the patient's medical record.
5. Required information is given to the patient and family at the time of admission.

Related standards:

PCC.11 Comfortable stay, PCC.04 Admission consent, PCC.09 Patient's needs, OGM.12 Billing System, ACT.01 Granting access, IMT. 08 Patient's Medical record Management, ICD.06 Medical patient assessments.

ACT.05 Appropriate and clear wayfinding signage is used to help patients and families to reach their destination inside the hospital.

Effectiveness

Keywords:

Wayfinding signage

Intent:

Navigation in the hospital could be a complex process, especially if it includes multiple buildings or structures. In addition, patients and families visiting healthcare campuses are often stressed. Wayfinding systems can help reduce their stress by providing easy-to-follow signage and legible directions to their destinations.

A key issue for the design and creation of wayfinding signage is the need to create it so that it helps every possible user type. People need to find their way, and lighting is very important when it comes to signage. Signage needs to be readable in different lighting conditions and different weathers (if it is used outdoors). In some settings, reliance on text-based messaging is minimized, and systems rely heavily on non-text cues such as colors and symbols.

Survey process guide:

- GAHAR surveyor may observe the readability, clarity, and acceptability of wayfinding signs, which include all those signs encountered by patients during their journey in the hospital.

Evidence of compliance:

1. All hospital areas are identified with signs.
2. Wayfinding signs are used in all relevant places to reduce patient and family confusion.
3. When color-coded signage is used, clear instructions on what each color means should be available.
4. Signs are visible and/or lit during all operating times.

Related standards:

PCC.02 Patient and family rights, EFS.01 Hospital environment and facility safety management, ACT.02 Registration process.

Effective and safe patient flow within the hospital.

ACT.06 There is a process in place to manage patient flow through the hospital.

Efficiency

Keywords:

Patient's flow risks.

Intent:

Patient flow is defined as the movement of patients, information, or equipment between departments, staff groups, or hospitals as part of a patient care pathway. Designing healthcare systems with effective patient flow is essential to providing safe, effective patient care. Poor flow can lead to increased costs, poor quality, and poor patient experience. The goal of seamless patient flow across care settings is often blocked by a lack of integration both within the hospital and between hospitals. Increasing demand and capacity issues in the healthcare systems have led to bottlenecks in hospitals for scheduled and unscheduled care. When this is combined with suboptimal coordination between various departments and services, efficient patient

flow is interrupted. Risk assessment is a systematic process of evaluating and analyzing potential hazards and threats that could lead to negative consequences. A proper risk assessment for patient flow shall address locations, timings, and conditions that lead to peak occupancies and peak flows. Hospitals perform a risk assessment to identify areas in the hospital where bottlenecks exist, then create a systematic, standardized, and shared approach for enhancing patient flow, putting patients' needs and opinions at the center of care strategies.

The risk management plan shall address multiple scenarios of patient flow, identify bottlenecks and crowding areas, and improve actions/projects to achieve more efficient patient flow through redesigning care processes, supporting access to care in an approved timeframe, and optimizing the use of healthcare resources. The risk assessment should be updated on a regular basis, followed by mitigation of identified risks to achieve more efficient patient flow.

Survey process guide:

- GAHAR surveyor may review the hospital's risk assessment documents to ensure coverage of all hospital areas.
- GAHAR surveyor may interview involved staff members to inquire about the steps taken to improve patient flow.
- GAHAR surveyor may observe the hospital's existing bottlenecks or crowding places and then compare them with the hospital's risk assessment to ensure its comprehensiveness.

Evidence of compliance:

1. There is a risk assessment for patient flow that addresses all hospital areas.
2. Relevant stakeholders participate in performing the risk assessment.
3. Bottlenecks/crowded places are identified.
4. Actions are taken to improve patient flow.

Related standards:

PCC.02 Patient and family rights, ACT.05 Wayfinding signage, QPI.9 Risk Management Program.

ACT.07 The hospital has a process guiding the assignment of patient care responsibility.

Safety

Keywords:

Patient's care responsibility

Intent:

Patients often require concurrent care from multiple healthcare professionals in hospitals and healthcare institutions. Multiple physicians may also care for patients in large clinics or other healthcare facilities.

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 result in an adverse event and increased medico-legal risk.

Identifying the most responsible physician and properly managing handovers of care improves patient safety and reduces physicians' medico-legal risk by preventing potential breakdowns in the chain of communication both among healthcare team members and with the patient. This helps ensure that inconsistency or redundancy in care is avoided.

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

The hospital 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 hospitalized patient is assigned to one of the Most Responsible Physicians (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.
- d) The process to ensure clear identification of responsibility between the transfer of responsibility parties.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the process of assigning patient care responsibility.
- GAHAR surveyor may interview medical staff members to ensure their awareness of the hospital'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 hospital has an approved policy and procedure for assigning care responsibility that addresses all elements mentioned in the intent from a) through d).
2. The medical staff are aware of the contents of the policy.
3. The patient's medical record identifies the physician responsible for care.
4. A clear handover process is performed in cases of transfer of care responsibility.

Related standards:

ICD.15 Plan of Care, ACT.08 Handover communication, ACT.14 Patient's referral, transfer, temporary discharge, and discharge,

ACT.08 GSR.04 A standardized approach to handover communications, including an opportunity to ask and respond to questions, is implemented.

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 clarification, which subsequently decreases medical errors.

The hospital shall develop and implement a policy and procedures to guide the process of handover communication. The policy addresses at least the following:

- a) Standardized methods of communication, such as SBAR, ISOBAR, I PASS the BATON and others.
- b) Occasions when this method is used; this includes, but is not limited to, between different shifts (in the same department) and between different levels of care (different departments/ services).
- c) The requirement of staff presence.
- d) Staff responsibilities.
- e) Recommended environment.

- f) Recording of the process, such as a handover logbook, endorsement form, electronic Handover tool, and/or other methods, as evidence of implementation; this documentation is not required to be included in the patient's medical file.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the process of handover communication, to check the presence of recommended framework (such as SBAR, ISOBAR, I PASS the BATON, etc.), staff responsible, recommended environment, and recording.
- GAHAR surveyor may interview healthcare professionals to ensure their awareness of the hospital's policy.
- GAHAR surveyor may review medical records, handover logbooks, endorsement forms, electronic handover tools, and/or other methods as evidence of implementation.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through f).
2. All healthcare professionals are aware of hospital policy.
3. Handover communication conducted between different shifts and between different levels of care (different departments/ services).
4. Handover communications are documented using an established tool or format and are accessible as needed.
5. The hospital monitors the reported data on handover communication and takes actions to control or improve the process as appropriate.

Related standards:

ICD.01 Uniform care, ACT.14 Patient's referral, transfer, temporary discharge, and discharge, ICD.16 Clinical practice guidelines adaptation and adoption, ICD.19 Critical results, ICD.15 Plan of Care.

ACT.09 The hospital has a process in place guiding the provision of second opinion.

Patient-centeredness

Keywords:

Second opinion

Intent:

The second opinion is an independent professional review and assessment performed to confirm, add to, or revise the diagnoses and proposed treatment of another healthcare professional. A patient has the right to seek and undergo the same evaluation process with another medical staff member to determine if the first diagnosis is accurate and that the prescribed treatment plan is the most effective and efficient. Aside from a confirmation process, a second opinion can be sought if the patient is not satisfied with the initial diagnosis and treatment plan and wishes to explore other treatment approaches and another opinion. A second opinion on a surgical procedure may be recommended if the procedure is deemed as a non-emergency.

Thus, getting a second opinion has many benefits, including implementing patient rights, confirming a new diagnosis, or recommending a different treatment plan.

The hospital is aware of the circumstances in which obtaining a second opinion may be the best course of action for the patient's care, such as when the patient has already received treatment but still experiences symptoms, when there are multiple underlying medical issues, or when the recommended course of action is risky, entails invasive surgery, or has long-term effects. However, due to a lack of resources or knowledge, some hospitals might be unable to offer second opinions. In these cases, hospitals need to facilitate and provide information to patients about available resources outside the hospital. The hospital shall develop and implement a policy and procedures to guide the

process of providing a safe and effective second opinion process. The policy addresses at least the following:

- a) Defined criteria for getting a second opinion for patients.
- b) A clear process of communicating second opinion requests to concerned healthcare professionals.
- c) A clear process of communicating essential information to the second opinion healthcare professionals.
- d) Timeframe to respond to second opinion requests.
- e) Response details to ensure safe and appropriate care planning.
- f) Actions to be taken when the hospital can't provide a second opinion.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the second opinion process.
- GAHAR surveyor may interview involved medical staff members to ensure their awareness of the hospital's policy.
- GAHAR surveyor may interview patients and families to check their awareness of the process.
- GAHAR surveyor may review a sample of medical records to assess the second opinion process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through f).
2. All medical staff members involved in a second opinion are aware of the hospital policy.
3. Second opinions are provided if applicable.
4. When second opinions cannot be provided by the hospital, patients and their families are notified of other alternatives.
5. The process of requesting, communicating, and responding to second opinion requests is recorded in the patient's medical record.

Related standards:

PCC.02 Patient and family rights, ACT.11 Multidisciplinary Management, ICD.15 Plan of Care, IMT.01 Information Management Processes

ACT.10 The consultation process is available and provided based on the patient's needs and within a predefined time frame.

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 is usually requested in an efficient manner that expedites patient care, situations occur in which the relationship between healthcare professionals results in an inefficient, less-than-collegial consultative process that may not be in the patient's best interest. For example, a patient and a consultant may be put at a serious disadvantage when consultation is requested late in the care process or is not accompanied by sufficient background information, the

reason for consultation is not clearly stated, or there is a late response to the consultation request. The hospital shall develop and implement a safe and appropriate consultation process.

The policy addresses at least the following:

- a) Requirements/criteria for getting a consultation for patients.
- b) Expected outcome and urgency of consultation.
- c) A clear process of communicating consultation requests to concerned healthcare professionals.
- d) Timeframe to respond to consultation requests.
- e) Response details to ensure safe and appropriate care planning.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the consultation process.
- GAHAR surveyor may interview involved healthcare professionals to ensure their awareness of the hospital's policy.
- GAHAR surveyor may review a sample of medical records to assess the consultation process and ensure compliance with the hospital policy.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through e).
2. Healthcare professionals who are involved in the consultation are aware of the hospital policy.
3. Consultations are obtained based on patient needs.
4. Consultations are obtained within a defined timeframe.
5. Information exchange between consultation requestor and responder to consultation requests is comprehensive and recorded in the patient's medical record.

Related standards:

ACT.11 Multidisciplinary Management, ICD.03 Medical patient assessments, ICD.15 Plan of Care, ICD.06 Medical patient assessments, IMT.01 Information Management Processes.

ACT.11 The Multidisciplinary management process is accessible and provided according to the patient's condition and needs.

Safety

Keywords:

Multidisciplinary Management

Intent:

A multidisciplinary management process usually occurs in the form of a meeting of a group of professionals from one or more clinical disciplines who together make decisions regarding the recommended treatment of individual patients. Multidisciplinary teams may specialize in certain conditions, such as cancer, diabetes, or other conditions. Clinical decisions are made based on reviews of clinical documentation such as case notes, test results, diagnostic imaging, etc. The patient may or may not be present during the multidisciplinary management meetings. Healthcare professionals defined multiple areas for improvement in multidisciplinary management, including access to complete information and clarified roles for the different healthcare professionals. The hospital shall develop and implement a policy and procedures guiding a safe and appropriate multidisciplinary medical management process.

The policy addresses at least the following:

- a) Defined criteria for getting multidisciplinary opinions.
- b) Clear responsibilities among the treating team.
- c) Recording details of communication, assessment, and care.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the multidisciplinary medical management process.
- GAHAR surveyor may interview medical staff members to ensure their awareness of the hospital's policy.
- GAHAR surveyor may review a sample of medical records for those patients with complex medical conditions, such as internal medicine, oncology, or critical care, to assess the process implementation and ensure compliance with the hospital policy.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through c).
2. All medical staff members are aware of the hospital policy.
3. Multidisciplinary management meetings are obtained based on patient needs.
4. Multidisciplinary management meetings occur according to the policy.
5. Information exchange between multidisciplinary management teams describes the patient's conditions and important findings and is recorded in the patient's medical record.

Related standards:

ICD.06 Medical patient assessments, ICD.15 Plan of Care, ICD.16 Clinical practice guidelines adaptation and adoption.

ACT.12 Transportation of patients is coordinated and provided in an approved timeframe.

Safety

Keywords:

Patient's Transportation

Intent:

In this standard, transportation refers to the act of lifting, maneuvering, positioning, and moving patients from one point to another while they are in the custody of hospital 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 hospital should coordinate patient transportation between hospital departments and services. The hospital should be able to meet patient needs within an approved timeframe. Patient transportation should be facilitated and coordinated within the available services and resources. The hospital 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 the examination bed, trolley, wheelchair, and other transportation means.
- b) A coordination mechanism is needed to ensure safe transportation within the approved timeframe.
- c) Competence of staff responsible for handling and transportation of patients.
- d) Staff safety while lifting and handling patients.
- e) Defined criteria to determine the appropriateness of transportation within the hospital.

Survey process guide:

- GAHAR surveyor may review the hospital policy for managing patient transportation.
- GAHAR surveyor may interview healthcare professionals to ensure their awareness of the hospital's policy.

- GAHAR surveyor may review a sample of medical records to assess the process implementation and ensure compliance with the hospital policy.
- GAHAR surveyor may observe the mechanisms of lifting, handling, and/or transporting patients.
- GAHAR surveyor may observe equipment used for lifting, handling, and/or transporting patients.

Evidence of compliance:

1. The hospital 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 hospital's policy.
3. Only 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 recorded in the patient's medical record.

Related standards:

ACT.14 Patient's referral, transfer, temporary discharge, and discharge, EFS.01 Hospital environment and facility safety management, WFM.08 Continuous Education Program, WFM.09 Staff performance Evaluation, ICD.15 Plan of Care.

ACT.13 The hospital grants access to intensive care and specialized care units and discharge from these units based on clear criteria.

Equity

Keywords:

Special care units' access

Intent:

Specialized care units refer to inpatient units that are specifically designed, staffed, and equipped for the continuous observation and treatment of critically ill or complex patients, including all types of intensive care units, as well as intermediate care or step-down units. Critical care units and specialized care units are subject to increasing demand, decreasing supply, decreasing quality of care, and rising administrative costs of healthcare provision. Hospitals should preserve the availability of needed and necessary critical and specialized care services to titrate demand-to-need at its most sensitive level; this can be maintained by:

- a) Defined physiologic-based admission criteria for the intensive care and specialized units and/or specific conditions defined by appropriate healthcare professionals in the hospital.
- b) Defined physiologic-based discharge criteria for the intensive care and specialized units and/or specific conditions defined by appropriate healthcare professionals in the hospital.

Survey process guide:

- GAHAR surveyor may review the hospital application to GAHAR to be aware of special units in the hospital.
- GAHAR surveyor may review a document describing the approved hospital process for admission and discharge from critical care and special care areas.
- GAHAR surveyor may interview involved healthcare professionals to check their awareness of the process.
- GAHAR surveyor may review patients' open medical records when visiting critical care units, dialysis units, or other units with the team to check the special additional screening used to decide admission and discharge from intensive care and special care units.

- GAHAR surveyor may observe to ensure that special resources, such as beds, equipment, or expertise, are allocated wisely according to the patient's special needs,
- during visiting critical care units, dialysis units, or other units.

Evidence of compliance:

1. The hospital has approved admission and discharge criteria for intensive care and specialized units.
2. All staff members involved in the admission and discharge of patients from specialized and critical care units are aware of the approved criteria.
3. Only competent staff members are allowed to admit and discharge patients from critical and specialized care units.
4. Admission and discharge of patients from critical and specialized care units occur when criteria are met.

Related standards:

ACT.07 Patient's care responsibility, ICD.01 Uniform care, ACT.01 Granting access (before patient's registration), ICD.15 Plan of Care, CSS.01 Critical care.

Effective and safe patient flow out of the hospital.

ACT.14 Processes of patient referral, transfer outside the hospital, temporary discharge, and discharge are defined.

Safety

Keywords:

Patient's referral, transfer, temporary discharge, and discharge.

Intent:

A referral is when the patient leaves the hospital to seek additional medical care temporarily in another organization. For hospitals, 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.

A transfer is when the patient leaves the hospital and gets transferred to another organization, such as a tertiary care organization, a rehabilitation organization, or a nursing home.

Discharge from the hospital is the point at which the patient leaves the hospital and returns home. Temporary discharge is when a patient may require a brief time off unit absence during their admission due to clinical needs, cultural needs, preferences, and expectations of the patients and families. Discharge, referral, and transfer involve the medical instructions that the patient will need to fully recover.

The hospital shall develop and implement a policy and procedures to guarantee the appropriate patient discharge, referral, and transfer-out, which is based on the identified patient's needs and guided by clinical guidelines/protocols. The policy addresses at least the following:

- a) Planning for discharge, temporary discharge, referral, and/or transfer out begins once diagnosis or assessment is settled and, when appropriate, includes the patient and family.
- b) A qualified individual is responsible for ordering and executing the patient discharge, referral, and/or transfer out.
- c) Defined criteria determine the appropriateness of referrals and transfers-out based on the approved scope of service and patient's needs for continuing care.

- d) Coordination with transfer/ referral agencies, if applicable, other levels of health service and other organizations.
- e) Referral/transfer sheets are complete and include at least the following:
 - i. Patient identification
 - ii. Reason for referral/transfer.
 - iii. Collected information through assessments and care.
 - iv. Medications and provided treatments.
 - v. Transportation means and monitoring required.
 - vi. Condition on referral/transfer.
 - vii. Destination on referral/transfer.
 - viii. Name of the medical staff member who decided the patient referral/transfer.

Survey process guide:

- GAHAR surveyor may review the hospital policy and related forms/sheets/documents guiding the approved hospital processes for referrals, transfers, temporary discharge, and discharges.
- GAHAR surveyor may interview involved staff members to ensure their awareness of the hospital policy.
- GAHAR surveyor may review a sample of the patient's medical records for patients who were transferred, referred, or discharged to check the related sheets and ensure their completeness.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through e).
2. All staff members involved in the discharge, temporary discharge, referral, or transfer of patients are aware of the hospital policy.
3. The discharge, temporary discharge, referral, and/or transfer-out orders are clearly recorded in the patient's medical record.
4. Referral/transfer sheets are complete with all the required elements from i) to viii) in the intent.
5. The referral feedback is reviewed, signed, and recorded in the patient's medical record.

Related standards:

PCC.02 Patient and family rights, ACT.01 Granting access (before patient's registration), ACT.07 Patient's care responsibility, ACT.08 Handover communication, ACT.12 Patient's transportation, ICD.15 Plan of Care.

ACT.15 Discharge summaries are complete.

Safety

Keywords:

Discharge summary

Intent:

Discharging patients from a hospital is a complex task. An essential part of this process is the documentation of a discharge summary. To ensure continuity of care and services, patient information is transferred to the patient when possible.

A discharge summary is a clinical report prepared by a healthcare professional at the conclusion of a hospital stay or a series of treatments. It explains how patient care is managed during hospitalization and is considered evidence of care provided to the patient. It is often the primary mode of communication between the hospital care team and healthcare professionals.

It is considered a legal document, and it has the potential to jeopardize the patient's care if errors are made. Delays in the completion of the discharge summary are associated with higher rates of readmission, highlighting the importance of successful transmission of this record in an approved timeframe. This requires clear communication and a coordinated effort from the entire team.

The discharge summary includes at least the following:

- a) The reason for hospitalization.
- b) Provisional and/or final diagnosis.
- c) Investigations.
- d) Significant findings.
- e) Procedures performed.
- f) Medications (before/during) and/or other treatments.
- g) Patient's condition and disposition at discharge.
- h) Discharge instructions, including diet, medications, and follow-up instructions.
- i) Name of the medical staff member who discharged the patient.

Survey process guide:

- GAHAR surveyor may review a sample of the patient's medical record for patients who were discharged to check the completeness of the discharge summary, in compliance with the required elements, and ensure that a copy of the discharge summary is kept in the patient's medical record.
- GAHAR surveyor may interview involved healthcare professionals to check their awareness of the process.
- GAHAR may observe the patient receiving a discharge summary upon discharge.

Evidence of compliance:

1. Staff members involved in the process of patient discharge are aware of the mechanism to obtain a discharge summary.
2. Discharge summaries are recorded using all the required elements from a) through i).
3. A copy of the discharge summary is kept in the patient's medical record.
4. A copy of the discharge summary is given to the patient.

Related standards:

PCC.02 Patient and family rights, IMT. 01 Information Management Processes, ACT.14 Patient's referral, transfer, temporary discharge, and discharge, ACT.07 Patient's care responsibility.

ACT.16 The hospital 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.

To ensure consistency, quality, and efficiency in the delivery of telemedicine services, the hospital shall develop and implement a program that is overseen by a qualified and experienced clinical director to provide appropriate leadership and oversight for the selection, integration, interoperability, and effectiveness of equipment and health information systems used in the delivery of telemedicine services. 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 should be 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 personnel specific to the telemedicine industry.
- e) The process of overseeing outsourced telemedicine services or functions.
- f) The hospital provides a clear method for the patient to initiate an encounter for telemedicine services.
- g) The process of verifying and documenting patient/provider identities and physical locations for each telemedicine encounter.
- h) Adheres to generally accepted evidence-based guidelines relevant to the clinical services used for patient encounters.
- i) The process of triaging patients to determine their eligibility for the available telemedicine services.
- j) The process of ensuring the privacy and cybersecurity of protected health information (PHI) in accordance with applicable laws and regulations.
- k) The fees for telemedicine services, insurance coverage, and the billing process associated with the delivery and utilization of telemedicine services.
- l) Periodical evaluation of telemedicine services based on quality indicators, including access, effectiveness, and satisfaction.

Survey process guide:

- GAHAR surveyor may review the hospital program guiding telemedicine.
- GAHAR surveyor may interview and review the staff file of the telemedicine services clinical director to check his qualifications and experience.
- GAHAR surveyor may interview involved staff members to ensure their awareness of the hospital program.
- GAHAR surveyor may observe the availability of the resources required to sustain the planned telemedicine clinical services.

Evidence of compliance

1. The hospital has a program for telemedicine that addresses items from a) to l) in the intent, if applicable.
2. The hospital has the resources required to sustain the planned telemedicine clinical services based on program goals, if applicable.
3. The delivery of telemedicine services is overseen by a qualified medical staff.
4. All involved staff are aware of the program and received the required training.
5. The telemedicine services are periodically evaluated.

Related standards:

IMT. 01 Information Management Processes, IMT. 08 Patient's Medical record Management, ACT.01 Granting access (before patient's registration), PCC.13 Patient's dignity, privacy, and confidentiality, EFS.10 Medical Equipment Plan

Integrated Care Delivery

Chapter intent:

Optimal health and personal care rely on universally recognized approaches to identify and address complex issues. These approaches can be categorized in various ways. In this handbook, they are outlined within the framework of integrated care delivery, encompassing screening, assessment, reassessment, referral, and consultation. Following these steps, care plans are developed, which may include surgery, invasive procedures, medication, interventions, or other forms of integrated care. This approach ensures a comprehensive and coordinated response to individual health needs, promoting seamless, patient-centered care. Screening serves as a preliminary strategy to identify the potential presence of an undiagnosed disease in patients who do not yet exhibit symptoms. This high-level evaluation helps determine whether a more in-depth assessment is needed, thus conserving resources and time. In contrast, assessment is a more comprehensive and structured process involving a holistic patient examination. This includes listening to the patient's complaints, gathering detailed information about their medical history, and employing techniques such as observation, inspection, palpation, percussion, and auscultation. Clinical judgment plays a critical role in determining the scope of the assessment required. The process involves collecting sufficient relevant information to enable healthcare professionals to make informed conclusions about the patient's strengths, deficits, risks, and health issues.

Individualized care plans are created by multidisciplinary teams after gathering the patient's needs. Research indicates that this approach enhances care coordination, optimizes healthcare service utilization, and reduces hospital costs. Additionally, it increases patient satisfaction and engagement. This chapter covers several key areas, including a focus on uniformity of care, a description of the initial screening, assessment, and care provided at the patient's first point of contact with the hospital, and an outline of the fundamental processes for screening, assessment, reassessment, and care.

Chapter purpose:

- 1) Emphasis on uniformity of care
- 2) Standardize screening and assessment processes
- 3) Define special assessments based on patient needs

ICD Chapter Summary of Changes

Summary of Changes Chapter 4

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
ICD.01 KW: Uniform Care	ICD.01 KW: Uniform Care	<p>1) Added new EOCs:</p> <ol style="list-style-type: none"> 1. (EOC.01: The hospital has a policy to ensure its commitment to providing uniform care to all patients when a similar service is needed). • (EOC.02: All staff members involved in patient care are aware of the hospital policy). • (EOC.04 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). <p>2) Modified EOC: (EOC.03 Department heads collaboratively define clinical guidelines/protocols and other professional practice guidelines, to guide the uniform standards of care all over the hospital).</p>
ICD.02 KW: Prehospital care, ambulance care, emergency medical care during disasters	ICD.03 KW: Prehospital care, ambulance care, emergency medical care during disasters	<p>1) Modified EOC: (EOC.01: The hospital has an approved policy that covers all elements mentioned in the intent from a) through f).</p>
ICD.03 KW: Emergency Services	ICD.04 KW: Emergency Services ICD.06 KW: Emergency care recording	<p>3) Updated standard (ICD.03) by merging two standards (ICD.04 and ICD.06) in Hospital edition 2021.</p>
ICD.04 KW: Emergency Care Guidelines	ICD.05 KW: Emergency Care Guidelines	<p>1) Modified standard statement: (Clinical practice guidelines for emergency care are adopted and/or adapted as deemed appropriate for hospital scope of service).</p> <p>2) Modified EOC: (EOC.01 Emergency care guidelines/protocols are adopted and/or adapted for common emergencies as mentioned in the intent from a) through g) as per the hospital scope.</p> <p>3) Added a new EOC: (EOC.04 Emergency equipment, supplies, medications, and antidotes are readily available to facilitate the implementation of the guidelines/protocols as per the hospital scope).</p>

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
ICD.05 KW: Outpatient Services	ICD.07 KW: Outpatient Services	<p>2) Rephrasing of standard statement: (Outpatient services are available and provided to patients).</p> <p>3) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy that guides outpatient care; it addresses all the elements mentioned in the intent from a) through g). • (EOC.04: The assessment and reassessment are recorded in the patient's medical records). • (EOC.05: The plans of care and follow-up instructions are recorded in the patient's medical records).
ICD.06 KW: Medical patient assessments	ICD.08 KW: Medical patient assessments	<p>1. Modified EOC (EOC.03 Initial medical assessments are performed within 24 hours of hospitalization or more frequently as per patient needs and recorded in the patient's medical record).</p>
ICD.07 KW: Nursing patient assessments	ICD.09 KW: Nursing patient assessments	<p>3) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.03: Initial nursing assessments are performed upon admission within the timeframe identified in the policy as per patient needs). • (EOC.04: Nursing reassessments are performed as the frequency identified in the hospital policy and according to patient needs). • (EOC.05: Nurses' assessment and reassessment are timely recorded in the medical records).
ICD.08 KW: Screening for further assessment needs	ICD.10 KW: Screening of healthcare needs	<p>1) Rephrasing of standard statement to be: (Patient's needs for further assessment are identified based on defined screening processes).</p> <p>2) Modified EOC:</p> <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy to guide screening for patient's needs for further assessments including elements from a) through e) in the intent). • (EOC.02: Qualified individuals identify the criteria for screening patients for each healthcare need from i) to v). <p>3) Added a new EOC: (EOC.05: Patient's needs are assessed and managed by the specific service and care is recorded in</p>

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
ICD.09 KW: Pain screening, assessment, reassessment, and management	ICD.19 KW: Pain screening, assessment, reassessment, and management	the medical record). 3) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy to guide pain management processes that addresses all elements mentioned in the intent from a) through e). • (EOC.05: Pain screening, assessment, pain management plan, and reassessment are documented in the patient records). 4) Rephrasing of EOC: (EOC.03: All inpatients and outpatients are screened for pain using a valid and approved tool suitable for the patient population). 5) Added a new EOC: (EOC.04: A comprehensive pain assessment is performed when pain is identified from the screening).
ICD.10 KW: Fall assessment and prevention.	ICD.11 KW: Fall screening and prevention	1) Modified standard statement: (Patient's risk of falling is assessed, periodically reassessed, and managed). 2) Modified EOCs: (EOC.01, EOC.02 & EOC.05). 3) Added new EOCs: <ul style="list-style-type: none"> • (EOC.03: The hospital assesses and reassesses all inpatients for risk of fall using appropriate tools suitable for the patient population and documented in patient medical record). • (EOC.04: Outpatients with certain conditions, situations or locations will be screened for risk of fall).
ICD.11 KW: Pressure Ulcers Prevention	ICD.12 KW: Pressure Ulcers Prevention	1) Modified standard statement: (The Patient's risk of developing pressure ulcers is assessed, periodically reassessed, and managed). 2) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy to guide pressure ulcer risk assessment that addresses all elements mentioned in the intent from a) through f). • (EOC.02: Healthcare professionals are aware of the elements of the pressure ulcer risk assessment and of prevention measures).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<ul style="list-style-type: none"> • (EOC.04: The families of patients at higher risk of pressure ulceration are aware of and involved in prevention measures). <p>3) Added a new EOC: (EOC.03: The hospital assesses upon admission and reassesses each patient's risk for developing a pressure ulcer using appropriate tools suitable for the patient population).</p>
ICD.12 KW: Venous Thromboembolism Prophylaxis	ICD.13 KW: Venous Thromboembolism Prophylaxis	<p>1) Modified standard statement: (Patient's risk of developing venous thromboembolism (deep venous thrombosis and pulmonary embolism) is assessed, periodically reassessed, and managed).</p> <p>2) Modified EOCs (EOC.01, EOC.02, EOC.03, EOC.04).</p> <p>3) Added a new EOC: (EOC.05: Tailored care plans based on individual patient VTE risk assessments are conducted and recorded in the patient file).</p>
ICD.13 KW: Patient nutritional needs	ICD.20 KW: Patient nutritional needs	<p>1) Modified EOC: (EOC.02: Medical and nursing staff are aware of the hospital policy).</p> <p>2) Added a new EOC: (EOC.06: The hospital implements a process to ensure safety of food brought by families).</p>
ICD.14 KW: Special-needs patient populations	ICD.23 KW: Special-needs patient populations	<p>3) Rephrasing of Standard statement to be: (The hospital develops and implements a process to guide the provision of care for special patient populations).</p>
ICD.15 KW: Plan of Care	ICD.14 KW: Plan of Care	<p>1. Added a new EOC: (EOC.02: The plan of care addresses all the elements mentioned in the intent from a) to g) and is documented in the patient medical record).</p> <p>3) Rephrasing of EOCs: (EOC.03 and EOC.04).</p>
ICD.16 KW: Clinical practice guidelines adaptation and adoption	ICD.15 KW: Clinical practice guidelines adaptation and adoption	<p>1) Rephrasing of standard statement to be: (The process of adopting and adapting clinical practice guidelines is defined).</p> <p>2) Modified EOCs:</p>

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy that guides all the elements mentioned in the intent from a) through e). • (EOC.03: At least three clinical guidelines for the most common/high risk three diagnoses managed in the hospital are adopted/adapted in the hospital annually).
ICD.17 KW: Orders and requests	ICD.17 KW: Orders and requests DAS.14 KW: Minimal retesting intervals	Updated Standard by merging two standards (ICD.17 and DAS.14) in Hospital edition 2021.
ICD.18 KW: Verbal and telephone orders	ICD.18 KW: Verbal and telephone orders	<p>1) Modified standard statement: (Verbal or telephone orders are communicated and documented according to the defined process).</p> <p>2) Modified EOC: (EOC.01: The hospital has an approved policy guiding the communication of verbal and telephone orders that addresses at least all elements mentioned in the intent from a) through e).</p> <p>3) Added a new EOC: (EOC.03: All verbal and telephone orders are documented then read back by the receiver and confirmed by the ordering physician).</p> <p>4) Updated EOC (EOC.05) by merging two EOCs (EOC.04 and EOC.05) in Hospital edition 2021.</p>
ICD.19 KW: Critical results	ICD.30 KW: Critical results	<p>1) Modified standard statement: (Critical results are communicated in time and documented according to the defined process).</p> <p>2) Updated EOC (EOC.04) by merging two EOCs (EOC.04 and EOC.05) in Hospital edition 2021.</p>
ICD.20 KW: Ordering of blood and blood products	DAS.31 KW: Ordering of blood and blood products	<p>1) Rephrasing of standard statement to be: (The hospital has a process for requesting blood and/or blood component).</p> <p>2) Modified EOC: (EOC.02: The involved staff members are aware of the hospital policy).</p>
ICD.21	DAS.33	1) Modified standard statement: (Blood and/or blood components are transfused

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
KW: transfusion of blood and blood products	KW: transfusion of blood and blood products	according to professional practice guidelines).
ICD.22 KW: Recognition and response to clinical deterioration	ICD.37 KW: Recognition and response to clinical deterioration	<p>1) Rephrasing of standard statement: (The hospital has a hospital-wide process for recognition of and response to clinical deterioration).</p> <p>2) Modified EOC: (EOC.02: All staff members involved in direct patient care are trained on recognition of and response to clinical deterioration.)</p> <p>3) Rephrasing of EOC: (EOC.03: Recognition and response to clinical deterioration are done as per the hospital policy, using age specific criteria.)</p>

Sustaining uniform care

ICD.01 Care delivery is uniform when a similar service is needed regardless of patient background, location, or time of care.

Equity

Keywords:

Uniform Care

Intent:

Hospitals 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. Hospitals are expected not to discriminate between patients and to provide them with uniform medical care per their clinical requirements.

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

Hospitals can demonstrate a similar level of compliance across all departments and services and when a service is offered in a department under the supervision of another department (such as complying with dialysis protocols even if dialysis services are provided outside dialysis units).

Care is also uniform when giving care in temporary locations, e.g., patients boarding at the emergency room or waiting in another location for a bed. Patients in the ER waiting for ICU beds must receive the same level of care as ICU patients, with the same equipment and recourses as well as the same staff qualifications and competencies as per patient needs. Patients will receive the same level of post-anesthesia care, regardless of the location; e.g., a patient transferred directly from the OR to the ICU or any other unit must receive the same level of care as patients in the recovery room.

To ensure this, hospitals shall develop a policy that specifies what constitutes uniform care, what practices can be followed to ensure that patients are not discriminated against based on their background or category of accommodation, and how to report and investigate potential discrimination events.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding uniform care provision to all patients.
- GAHAR surveyor may interview involved staff members to check their awareness of the Hospital policy.
- GAHAR surveyor may observe to ensure compliance with the hospital policy.
- GAHAR surveyor may interview department heads to ask about clinical guidelines/protocols and other professional practice guidelines guiding the uniform standards of care all over the hospital.

Evidence of compliance:

1. The hospital has a policy to ensure its 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 hospital policy.
3. Department heads collaboratively define clinical guidelines/protocols and other professional practice guidelines to guide the uniform standards of care throughout the hospital.
4. 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.

Related standards:

PCC.03 Patient and family rights; ICD.16 Clinical practice guidelines adaptation and adoption; OGM.15 Ethical Management

ICD.02 Pre-hospital services are delivered according to applicable laws and regulations.

Effectiveness

Keywords:

Prehospital care, ambulance care, and emergency medical care during disasters

Intent:

Pre-hospital care is provided by emergency medical responders, who are the initial healthcare professionals at the scene of the incident.

Emergency medical responders are often the first to recognize the nature of a disaster and can immediately evaluate the situation and determine the need for resources, including other medical resources.

Hospitals might owe ambulances or contract another organization for the sourcing of ambulance services. This does not apply to the national ambulance system.

The hospital shall develop and implement a policy and procedures for pre-hospital care. The policy addresses at least the following:

- a) Provision, operation, or sourcing of ambulance services.
- b) Continuous readiness.
- c) The time frame for receiving calls, dispatching vehicles, and reaching patients.
- d) Screening, assessment, and reassessment of patients.
- e) Care protocols for patients at the scene and during transfer.
- f) Conducting drills to ensure continuous readiness.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding pre-hospital care.
- GAHAR surveyor may interview emergency staff members to check their awareness of the Hospital policy.
- GAHAR surveyor may review a sample of the patient's medical records to check pre-hospital care records completeness.

Evidence of compliance:

1. The hospital has an approved policy that covers all elements mentioned in the intent from a) through f).
2. Emergency staff members are aware of the hospital policy.
3. Pre-hospital care records are complete and kept in the patient's medical record.
4. There is a process of recording and monitoring of response times.

Related standards:

ICD.03 Emergency services; ICD.04 Emergency care guidelines

Effective emergency and outpatient services

ICD.03 Urgent and emergency services are delivered according to applicable laws and regulations.

Effectiveness

Keywords:

Emergency Services

Intent:

To ensure consistency and coordination of services with higher levels of care, emergency services offered to the community should be provided within the capabilities of the hospital as defined by law and regulations.

The hospital shall develop and implement a policy and procedures for emergency services. The policy addresses at least the following:

- a) The staff qualifications required to provide emergency care around the clock, including ALS for medical staff.
- b) Defined criteria are developed to determine the priority of care according to an evidence-based triage process.
- c) The minimum requirements for medical and nurse emergency assessment and reassessment.
- d) The care process follows approved clinical guidelines and protocols, including requesting investigations and consultations and holding patients for observations.
- e) The medical records of emergency patients should include at least:
 - i) The triage assessment and level.
 - ii) The medical and nurses' assessment and reassessment.
 - iii) The care provided.
 - iv) The arrival time and departure time.
 - v) Patient disposition.
 - vi) Patient diagnosis or conclusion at termination of treatment.
 - vii) Patient condition at departure.
 - viii) Follow-up care instructions.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding emergency services.
- GAHAR surveyor may interview emergency staff members to check their awareness of the Hospital policy.
- GAHAR surveyor may review a sample of emergency staff members' files to check their competency assessment.
- GAHAR surveyor may review a sample of emergency patients' medical records to ensure compliance with hospital policy requirements.
- GAHAR surveyor may observe to ensure emergency patients prioritization based on the urgency of their condition, in compliance with the hospital's evidence-based triage criteria for different populations.

Evidence of compliance:

1. The hospital has an approved policy for emergency services as mentioned in the intent from a) to e).
2. Competent staff members provide emergency services according to the policy of emergency services.
3. Patients are prioritized based on the urgency of their condition using evidence-based triage criteria for different populations, such as adults and pediatrics, and/or according to the scope of service.
4. Emergency patients receive medical, and nurses' assessments based on their needs and conditions.
5. Medical records of emergency patients include Items from i) to viii) in the intent.

Related standards:

ICD.04 Emergency care guidelines; ICD.02 Prehospital care, ambulance care; ICD.06 Medical patient assessments; ICD.07 Nursing patient assessments

ICD.04 Clinical practice guidelines for emergency care are adopted and/or adapted as deemed appropriate for the hospital's scope of service.

Effectiveness

Keywords:

Emergency Care Guidelines

Intent:

Clinical practice guidelines include recommendations intended to optimize patient care supported with an evidence-based assessment of the benefits and harms of alternative care options. Clinical guidelines are also intended to be a reference for clinical staff members caring for patients and are not intended to replace healthcare professionals' clinical judgment. The hospital shall adopt and/or adapt clinical guidelines/protocols that address at least the following (when applicable):

- a) Emergency stabilization and treatment of chest pain.
- b) Emergency stabilization and treatment of shock.
- c) Emergency stabilization and treatment of poly-trauma.
- d) Emergency stabilization and treatment of altered level of consciousness.
- e) Emergency stabilization and treatment of asthma
- f) Emergency stabilization and treatment of stroke
- g) Other emergencies selected based on the hospital's scope of services.

Survey process guide:

- GAHAR surveyor may review the emergency care guidelines/protocols for the common emergencies.
- GAHAR surveyor may interview relevant staff members to ensure their training on relevant emergency care protocols.
- GAHAR surveyor may review a sample of patients' medical records to ensure compliance with the emergency care guidelines/protocols.
- GAHAR surveyor may review a sample of relevant staff files to check their training records.
- GAHAR surveyor may observe to check the availability and accessibility of emergency equipment, supplies, medications, and antidotes.

Evidence of compliance:

1. Emergency care guidelines/protocols are adopted and/or adapted for common emergencies, as mentioned in the intent from a) through g), as per the hospital scope.
2. Relevant staff members are trained on relevant emergency care guidelines/protocols.
3. Emergency care guidelines/protocols are consulted during patient care processes.
4. Emergency equipment, supplies, medications, and antidotes are readily available to facilitate the implementation of the guidelines/protocols as per the hospital scope.

Related standards:

ICD.03 Emergency services; ICD.16 Clinical practice guidelines adaptation and adoption

ICD.05 Outpatient services are available and provided to patients.

Patient-centeredness

Keywords:

Outpatient Services

Intent:

Outpatient care covers a wide range of medical services, including consultations with healthcare professionals, diagnostic tests, minor surgical procedures, vaccinations, physical therapy sessions,

and more. It is a cost-effective and convenient option for patients with less severe or chronic medical conditions that do not necessitate inpatient hospitalization.

Hospitals experience increased trends in providing specialized healthcare clinics and subspecialized clinics. Assessment and reassessment are performed to evaluate patient health status, identify changes since the initial or most recent assessment, and determine new or ongoing needs. Reassessment findings determine the appropriateness of the current care plan and the need for any changes. Ensuring legible and comprehensive recording of findings plays a crucial role in maintaining continuity of care.

Hospitals shall develop and implement a policy and procedures for outpatient services that address at least the following:

- a) Scope and content of the patient screening required to determine the priority of the patient's medical and nursing care needs in the outpatient department.
- b) A competent staff member performs an initial screening process.
- c) Scope and content of the initial assessment, including history and physical examination.
- d) Responsibility for the completion of assessments.
- e) Recording of care plans.
- f) Frequency of reassessments through subsequent visits or follow-ups, whenever applicable.
- g) Documentation of patient and family education and follow-up instructions.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding outpatient care.
- GAHAR surveyor may interview outpatient staff members to check their awareness of the Hospital policy.
- GAHAR surveyor may review a sample of outpatient medical records to ensure assessment, reassessment, plan of care, and follow-up instructions documentation.

Evidence of compliance:

1. The hospital has an approved policy that guides outpatient care; it addresses all the elements mentioned in the intent from a) through g).
2. All outpatient staff members are aware of the approved outpatient care process.
3. All outpatients receive initial assessments within a defined time frame and responsibilities.
4. The assessment and reassessment are recorded in the patient's medical records.
5. The plans of care and follow-up instructions are recorded in the patient's medical records.

Related standards:

ICD.06 Medical patient assessments; ICD.07 Nursing patient assessments; ICD.15 Plan of Care

Effective basic screening and assessment of hospitalized patients

ICD.06 Initial medical assessment and subsequent 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 hospital 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.

The hospital 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 hospital also defines the timeframe for completing the initial assessment, which is guided by clinical guidelines. The hospital also defines whenever history and physical examination completed prior to hospitalization may be used and whether hospital medical staff members verify and/or accept the results of patient assessments performed outside the hospital.

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy to guide initial assessment and define its timeframe and minimum content as per the elements from a) through j) in the intent.
2. Healthcare professionals are qualified and aware of the components of the initial assessment.
3. Initial medical assessments are performed within 24 hours of hospitalization or more frequently as per patient needs and recorded in the patient's medical record.
4. All examinations, investigations, and results done before hospitalization are managed uniformly.
5. Medical reassessments are performed, as per the policy, and recorded in the patient's medical record.

Related standards:

ICD.07 Nursing patient assessments; ICD.15 Plan of Care; ICD.14 Special-needs patient populations

ICD.07 Initial nursing assessments and reassessments are performed.

Effectiveness

Keywords:

Nursing patient assessments

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 hospital 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 hospital 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.

The hospital 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 hospital policy guiding nursing initial assessment.
- GAHAR surveyor may interview nurses to check their awareness of the hospital policy.
- GAHAR surveyor may observe the compliance with the hospital 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 hospital policy.

Evidence of compliance:

1. The hospital 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 hospital policy and according to patient needs.
5. Nurses' assessment and reassessment are timely recorded in the medical records.

Related standards:

ICD.08 Screening for further assessment needs; ICD.11 Pressure Ulcers Prevention; ICD.09 Pain screening, assessment, reassessment, and management; ICD.10 Fall assessment and prevention; ICD.15 Plan of Care

Patient-tailored screening, assessment, and care processes

ICD.08 Patient's needs for further assessment are identified based on defined screening processes.

Patient-centeredness

Keywords:

Screening for further assessment needs

Intent:

Many people, especially those with chronic conditions, have complex health needs. A holistic approach to patient care requires addressing all patients' needs, even the non-expressed ones.

Nutritional screening is a first-line process for identifying patients who are already malnourished or at risk of becoming so. Nurses and/or medical staff members usually perform nutritional screening, and patients found at risk of nutritional status are referred to a nutritionist for further nutritional assessment. Functional screening helps to determine underlying neurological or developmental conditions. Usually, nurses and/or medical staff members perform the screening, in which patients at risk of functional status are referred to a physiatrist, physiotherapist, occupational therapist, speech therapist, or others for further functional assessment.

Psychosocial screening can help identify behavioral issues and social determinants of health. A nurse and/or medical staff may perform psychosocial screening, and patients at risk will be referred to a social worker, psychologist, or other qualified staff for further psychological and/or social assessment. The patient will be screened for discharge needs early upon admission by a medical staff member and/or a nurse or other qualified healthcare staff member to address needs affecting smooth discharge and issues that may impact the progress of the patient's condition.

Signs of abuse and neglect may be screened and recorded by a medical staff member or a nurse, then referred to another specialty or a committee for further assessment or management.

The hospital shall develop and implement a policy and procedures to guide the screening process for healthcare needs. The policy addresses at least the following:

- a) The screening criteria for each of the following healthcare needs.
 - i. Nutritional status
 - ii. Functional status
 - iii. Psychosocial status
 - iv. Discharge needs.
 - v. Victims of abuse and neglect
- b) The qualified individuals responsible for setting the criteria for screening patients for each healthcare need from i) to v).
- c) Timeframe to complete healthcare needs screening.
- d) Process for identifying the need for further assessment by the specific service when defined criteria are met.
- e) The documentation requirements of the screening from i) to v) and the referral process as applied.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the healthcare needs screening process.
- GAHAR surveyor may interview involved healthcare professionals to check their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to ensure the patient's needs screening, assessment, and management documentation completeness, in compliance with the hospital policy.

Evidence of compliance:

1. The hospital has an approved policy to guide screening for patients' needs for further assessments, including elements from a) through e) in the intent.
2. Qualified individuals identify the criteria for screening patients for each healthcare need from i) to v).
3. All screens are completed and recorded within an approved timeframe and responsibilities.
4. Patients are referred for further assessment by the specific service when defined criteria are met.
5. Patient's needs are assessed and managed by the specific service, and care is recorded in the medical record.

Related standards:

ICD.06 Medical patient assessments; ICD.07 Nursing patient assessments; ICD.15 Plan of Care

ICD.09 Inpatients and outpatients 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. When properly managed, pain leads to patient comfort, proper role function, and satisfaction. The hospital 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 tools suitable for different patient populations as per the hospital scope, i.e., tools for adults, pediatrics, neonates, and cognitively impaired patients.
- b) Complete pain assessment elements that include pain intensity, character, location, frequency, and duration.
- c) Frequency of pain reassessments.
- d) Pain management protocols.
- e) Competent staff responsible for pain management.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding pain management processes.
- GAHAR surveyor may interview relevant staff members to check their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to assess the pain screening tool and check its documentation.
- GAHAR surveyor may review a sample of patients' medical records to check the pain assessment, management plan, and reassessment documentation.

Evidence of compliance:

1. The hospital has an approved policy to guide pain management processes that address all elements mentioned in the intent from a) through e).
2. All relevant staff members are aware of the policy.
3. All inpatients and outpatients are screened for pain using a valid and approved tool suitable for the patient population,
4. A comprehensive pain assessment is performed when pain is identified from the screening.
5. Pain screening, assessment, pain management plan, and reassessment are documented in the patient records.

Related standards:

ICD.06 Medical patient assessments; ICD.07 Nursing patient assessments; ICD.15 Plan of Care

ICD.10 GSR.05 Patient's risk of falling is assessed, periodically reassessed, and managed.

Safety

Keywords:

Fall 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 risk assessment process in order to offer tailored preventative measures against falling. 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 hospital shall develop and implement a policy and procedures to guide the fall risk assessment and prevention process. The policy addresses at least the following:

- a) Patient fall risk assessment on admission.
- b) Assessment contents are based on guidelines.
- c) Timeframe to complete fall assessment and frequency of reassessment.
- d) The screening criteria for outpatient and ambulatory locations, situations, and conditions that may increase the risk of falls.
- e) Fall risk prevention strategies for patients found at risk of falls.
- f) General measures that are used to reduce the risk of falling, such as call systems, lighting, corridor bars, bathroom bars, bedside rails, wheelchairs, and trolleys with locks.
- g) Tailored care plans based on individual patient fall risk assessment.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the assessment of the patient's risk for falls.
- GAHAR surveyor may interview Healthcare professionals to check their awareness of the hospital policy.
- GAHAR surveyors may interview families of patients at higher risk to assess their awareness of and involvement in prevention measures.
- GAHAR surveyor may review a sample of patients' medical records to check fall risk assessment and re-assessment tool and its documentation.
- GAHAR surveyor may review a sample of patients' medical records, to check general measures and tailored care plans recording.
- GAHAR surveyor may observe organization-wide general preventive measures such as call systems, lighting, corridor bars, bathroom bars, bedside rails, wheelchairs, and trolleys with locks.

Evidence of compliance:

1. The hospital has an approved policy to guide the assessment of a patient's risk of fall that includes all elements in the intent from a) through g).
2. Healthcare professionals are aware of the elements of approved policy.
3. The hospital assesses and reassesses all inpatients for risk of fall using appropriate tools suitable for the patient population and documented in the patient's medical records.
4. Outpatients with certain conditions, situations, or locations will be screened for risk of falls.
5. The families of patients who are at higher risk of falling are aware of and involved in fall prevention measures.
6. General measures and tailored care plans are recorded in the patient's medical record.

Related standards:

ICD.07 Nursing patient assessments; ICD.15 Plan of Care; PCC.07 Patient and family education process

ICD.11 GSR.06 The Patient's risk of developing pressure ulcers is assessed, periodically reassessed and managed.

Safety

Keywords:

Pressure Ulcers Prevention

Intent:

The use of pressure ulcer risk assessment tools or scales is a component of the assessment process used to identify patients at risk of developing a pressure ulcer. The use of a risk assessment tool is recommended by many international pressure ulcer prevention guidelines; identifying patients who are more prone to develop pressure ulcers is a better preventive strategy than trying to treat them. Tailoring pressure ulcer prevention measures to each patient is proven to be effective.

The hospital shall develop and implement a policy and procedures to guide the pressure ulcer screening and prevention process. The policy addresses at least the following:

- a) Pressure ulcer risk assessment is performed upon admission.
- b) Contents of assessment based on guidelines.
- c) Timeframe to complete pressure ulcer assessment.
- d) Frequency of reassessment of risk of pressure ulcer development.
- e) General measures are used to reduce the risk of pressure ulcers, such as pressure relieving devices and mattresses.
- f) Tailored care plans based on individual patient pressure ulcer assessment.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding pressure ulcer risk assessment.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the pressure ulcer risk assessment elements and prevention measures.
- GAHAR surveyor may interview patients' families at higher risk to assess their awareness of and involvement in prevention measures.
- GAHAR surveyor may review a sample of the patient's medical records to check pressure ulcer risk assessment tools and tailored care plan documentation.
- GAHAR surveyor may observe the hospital's general measures to reduce the risk of pressure ulcers, such as pressure-relieving devices and mattresses.

Evidence of compliance:

1. The hospital has an approved policy to guide pressure ulcer risk assessment that addresses all elements mentioned in the intent from a) through f).
2. Healthcare professionals are aware of the elements of the pressure ulcer risk assessment and of prevention measures.
3. The hospital assesses upon admission and reassesses each patient's risk for developing a pressure ulcer using appropriate tools suitable for the patient population.
4. The families of patients at higher risk of pressure ulceration are aware of and involved in prevention measures.
5. General measures and tailored care plans are recorded in the patient's medical record.

Related standards:

ICD.07Nursing patient assessments; ICD.06 Medical patient assessments; ICD.15 Plan of Care; PCC.07 Patient and family education process

ICD.12 GSR.07 Patient's risk of developing venous thromboembolism (deep venous thrombosis and pulmonary embolism) is assessed, periodically reassessed and managed.

Safety

Keywords:

Venous Thromboembolism Prophylaxis

Intent:

Venous thromboembolism (VTE) is considered an important silent killer in hospitals. Adopting guidelines to reduce the risk of developing this condition is important for decreasing preventable adverse events and mortalities. The hospital shall adopt and implement a guideline for VTE prophylaxis. The guideline addresses at least the following:

- a) Patient risk assessment on admission.
- b) Contents and timeframe to complete VTE assessment.
- c) Reassessment of risk of VTE.
- d) Appropriate prophylaxis such as mechanical, pharmacological, or both according to risk severity.
- e) Tailored care plans based on individual patient VTE risk assessment.

Survey process guide:

- GAHAR surveyor may review the hospital's adopted VTE risk assessment and management guidelines.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the VTE risk assessment process elements and prevention measures.
- GAHAR surveyor may interview patients with a higher level of VTE risk and their families to assess their awareness of and involvement in the prevention measures.
- GAHAR surveyor may review a sample of the patient's medical records to check VTE risk assessment and tailored care plan documentation.
- GAHAR surveyor may observe compliance with the hospital's VTE guidelines.

Evidence of compliance:

1. The hospital has an approved guideline for assessment and management of patient's VTE risk that addresses all elements mentioned in the intent from a) through e).
2. Healthcare professionals are aware of the elements of the VTE assessment process and of prevention measures.
3. VTE risk assessments are completed and recorded within an approved timeframe.
4. The families of patients at higher risk for VTE are aware of and involved in prevention measures.
5. Tailored care plans based on individual patient VTE risk assessments are conducted and recorded in the patient files.

Related standards:

ICD.06 Medical patient assessments; ICD.16 Clinical practice guidelines adaptation and adoption; ICD.15 Plan of Care; PCC.07 Patient and family education process

ICD.13 Patients' special nutritional needs are assessed and managed.

Patient-centeredness

Keywords:

Patient nutritional needs

Intent:

A nutrition assessment is an in-depth evaluation of both objective and subjective data related to a patient's food and nutrient intake, lifestyle, and medical history. Once the data on an individual is collected and organized, the healthcare professional can assess and evaluate the nutritional status of that person. The assessment leads to a plan of care, or intervention, designed to help the patient either maintain the assessed status or attain a healthier status. The hospital shall develop and implement a policy and procedures for assessment, reassessment, and management of nutritional needs.

The policy addresses at least the following:

- a) Availability of competent individuals for assessment and management of patient's nutritional needs.
- b) Defined criteria for the involvement of nutritional services in the patient care process.
- c) Components of nutritional assessment.
- d) Management of patient's nutritional needs:
 - I. A list of all special diets is available and accommodated.
 - II. Ordering of food is appropriate to the patient's clinical condition.
 - III. Ordering for food or other nutrients is recorded in the medical record.
 - IV. Scheduling for meals and timings of distribution of meals complies with patient's preferences.
- e) Process to ensure the safety of food brought by the family.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the assessment, reassessment, and management of patient's nutritional needs and the hospital's special diets list.
- GAHAR surveyor may interview medical and nursing staff to check their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to ensure the patient's nutritional needs assessment and management documentation.
- GAHAR surveyor may review a sample of responsible healthcare professionals' files to check their qualifications.
- GAHAR surveyor may observe compliance with the hospital policy, including the process for the safety of food brought by the family.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through e).
2. Medical and nursing staff are aware of the hospital policy.
3. Qualified healthcare professionals are responsible for the assessment and management of the patient's nutritional needs.
4. The patient's nutritional needs are assessed and managed according to the policy.
5. The patient's nutritional needs assessment and management is recorded in the patient's medical record.
6. The hospital implements a process to ensure the safety of food brought by families.

Related standards:

ICD.06 Medical patient assessments; ICD.07 Nursing patient assessments; ICD.15 Plan of Care, PCC.07 Patient and family education process

ICD.14 The hospital develops and implements a process to guide the provision of care for special patient populations.

Patient-centeredness

Keywords:

Special-needs patient populations

Intent:

The greater need for healthcare services among special needs populations is generally costlier to the system, especially if care is not managed appropriately. Members with special healthcare needs populations may also have unique challenges in accessing care and are often overlooked in the context of broader services. Thus, the hospital shall develop and implement a policy and procedures for the assessment, reassessment, and management of special-needs patient populations. The policy addresses at least the following:

- a) Identification of special-needs patient populations that visit the hospital and need to modify the general assessment form, which should include at least the following:
 - I. Neonates.
 - II. Pediatrics.
 - III. Adolescents
 - IV. Elderly
 - V. Immunocompromised
 - VI. Patients with communicable diseases
 - VII. Patients with special psychosocial needs
 - VIII. Victims of abuse and neglect
- b) Availability of competent individuals for assessment and management of special patient populations needs.
- c) Required modifications for regular patient assessment methods to match special patient populations' needs.
- d) Management and care for special patient populations needs through an individualized plan of care.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding assessment, reassessment, and management of special-needs patient populations.
- GAHAR surveyor may interview inpatient medical and nursing staff members to check their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patient's medical records to check special patient populations' needs assessment and management documentation.
- GAHAR surveyor may observe to ensure compliance with the hospital policy.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through d).
2. All inpatient medical and nursing staff members are aware of the hospital policy.
3. Special patient population needs are assessed and managed.
4. Special patient populations' needs assessment, and management is recorded in the patient's medical record.

Related standards:

ICD.06 Medical patient assessments; ICD.07 Nursing patient assessments; ICD.15 Plan of Care.

Effective care for hospitalized patients

ICD.15 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/family/community may need. The focus of a plan is to facilitate standardized, evidence-based, and holistic care.

A comprehensive care plan is developed for each patient, outlining the specific medical treatments, medications, and therapies required. Additionally, the plan considers psychosocial support, dietary needs, and rehabilitation services to address all aspects of the patient's health.

Effective communication is crucial for care coordination. Team members regularly exchange information about the patient's progress, treatment updates, and any changes in their condition.

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) Developed and updated according to guidelines and patient needs and preferences.
- e) Includes identified needs, interventions, and desired outcomes with timeframes.
- f) Updated as appropriate based on the reassessment of the patient.
- g) The progress of the patient in achieving the desired outcomes of care is monitored.

Survey process guide:

- GAHAR surveyor may review a sample of patients' medical records to check plan of care documentation in compliance with the standard requirements.
- GAHAR surveyor may interview patients and their families to ensure their participation in the decision-making of their plan of care development.
- GAHAR surveyor may observe to ensure compliance with the standard requirements.

Evidence of compliance:

1. The plan of care is developed by all relevant disciplines based on their assessments.
2. The plan of care addresses all the elements mentioned in the intent from a) to g) and is documented in the patient medical record.
3. The plan of care is developed with the participation of the patient and/or family in decision-making.
4. The plan of care is changed/updated, as appropriate, based on the reassessment of the patient.

Related standards:

ICD.06 Medical patient assessments; ICD.07 Nursing patient assessments; ICD.16 Clinical practice guidelines adaptation and adoption; ACT.11 Multidisciplinary Management

ICD.16 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 hospital's unique context. Customizing guidelines to the specific hospital can enhance acceptance and adherence. Actively involving end-users in this process significantly improves practice changes.

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

- a) Procedures guided adoption and adaptation of clinical practice guidelines/protocols such as:
 - i. Guideline selection criteria such as indication and need, evidence-based, and relevance to the hospital's scope of work and capabilities.
 - ii. Expert panel formation.
 - iii. Initial assessment, adaptation, and customization.
 - iv. Local review by hospital leadership and other relevant hospital bodies to ensure that the guideline aligns with the hospital's overall strategic goals and maintains clinical quality.
 - v. Development of implementation plan.
- b) The hospital should adapt and adopt guidelines or protocol for at least the most common/high risk three diagnoses managed in the hospital annually.
- c) Feedback, monitoring, and evaluation during and after the implementation. The hospital continually monitors the impact of the adapted guideline on patient outcomes and adherence rates. This data helps identify successes and areas needing improvement.
- d) The hospital plans to implement approved national clinical practice guidelines whenever they are available.
- e) The adopted/adapted CPGs should be reviewed and updated at least every 2 years and as appropriate.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding clinical practice guidelines adoption and adaptation.
- GAHAR surveyor may interview medical and nursing leaders to check their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to ensure compliance with clinical practice guidelines.
- GAHAR surveyor may review a sample of staff members' files to check their training records.

Evidence of compliance:

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

Related standards:

ICD.04 Emergency Care Guidelines; QPI.06 Clinical Performance Measures.

ICD.17 Information is available to support medical orders and requests.

Safety

Keywords:

Orders and requests

Intent:

Orders and requests represent communication from a medical staff member directing that service to be provided to the patient. It may take several forms such as in writing, by telephone, verbally, electronic patient's medical record entries, physician order entry (POE).

The hospital should ensure that the required information is available for the patient and for those who are going to execute the order. Information includes at least the following:

- a) Name of the ordering medical staff members.
- b) Date and time of order.
- c) Patient identification, age, and sex.
- d) Clinical reason for ordering and requesting a service.
- e) Site and laterality for medical imaging studies.
- f) Prompt authentication by the ordering medical staff members.

Medical staff members should be educated to reduce unnecessary test and the minimal retesting intervals. Minimal retesting intervals are 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. Information should be available in the laboratory service manual regarding indications for repeating a test. Requests to repeat tests are restricted to a particular grade or level of staff.

Survey process guide:

- GAHAR surveyor may interview medical staff members to check their awareness of the full medical order/request requirements.
- GAHAR surveyor may review a sample of patients' medical records to ensure compliance with the full medical order/request requirements and assess completeness and accuracy.
- GAHAR surveyor may review laboratory service manual indications for repeating a test with a corresponding review of laboratory requests for repeated tests in the medical records to check compatibility.

Evidence of compliance:

1. All medical staff members are aware of the full order requirements.
2. Medical orders follow all the required elements mentioned in the intent from a) to f).
3. There is a process to evaluate the completeness and accuracy of orders and requests.
4. Physicians are contacted when an order or request is not clear, not complete, or needs more information.
5. Requests to repeat tests are restricted to a particular grade or level of staff, and the reasons to override the rules are explained.

Related standards:

ACT.03 Patient identification; DAS.04 Pre-examination process; DAS.14 Pre-examination process; MMS.11 Ordering, prescribing, transcribing.

ICD.18 GSR.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 hospital 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:

- GAHAR surveyor may review the hospital policy guiding the communication of verbal and telephone orders.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to check verbal and telephone orders recording.

Evidence of compliance:

1. The hospital has an approved policy guiding the communication of verbal and telephone orders 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 hospital monitors the reported data of verbal and telephone orders and takes actions to control or improve the process as appropriate.

Related standards:

ICD.19 Critical results; ACT.08 Handover communication

ICD.19 GSR.03 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 the completion of critical tests or in communicating the results of critical tests or critical test results to the requestor. Miscommunication is the most common root cause of adverse events. Writing down and reading back the results 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 laboratory, medical imaging service, non-interventional cardiology laboratory, and point-of-care testing program are defined as the critical values for specific tests/studies. The process includes instructions for immediate notification of the authorized individual responsible for the patient with results that exceed the critical intervals.

The hospital 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.
 - i. Date and time of notification.
 - ii. Identification of the notifying responsible staff member.
 - iv. Identification of the notified person.
 - v. Description of the sequence of conveying the result.
 - vi. Examination results conveyed.
 - vii. Any difficulties encountered in notifications.
- d) Measures to be taken in case of critical results.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding critical results communications.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records and dedicated related registers, especially in the hospital's laboratory, medical imaging service departments, non-interventional cardiology laboratory, and point of care testing areas to check critical results recording.

Evidence of compliance:

1. The hospital has an approved policy to guide critical results communications that address 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 within a predefined timeframe, including all elements in the intent from i) through vii).
4. The hospital monitors the reported data on critical results and takes actions to control or improve the process as appropriate.

Related standards:

ICD.18 Verbal and telephone orders, DAS.07 Medical imaging reports; DAS.22 STAT results

ICD.20 The hospital has a process for requesting blood and/or blood components.

Safety

Keywords:

Ordering of blood and blood products

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- nor 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 hospital 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 the 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 the transfusion so that the blood bank can check that the product ordered is suitable for diagnosis.
- e) Clearly communicate whether the blood is emergently or routinely needed.
- f) Sending the blood request form with the 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 hospital policy guiding safe blood transfusion service.
- GAHAR surveyor may interview involved staff members, especially in inpatient wards, procedure areas, emergency room and operative rooms, to check their awareness of hospital policy.
- GAHAR surveyor may interview blood bank staff members to check their received information.
- GAHAR surveyor may review a sample of patients' medical records to check recording of transfusion Indication and ensure blood transfusion orders completion, legibility and clarity.

Evidence of compliance:

1. The hospital has an approved policy that describes all elements mentioned in the intent from a) through g).
2. The involved staff members are aware of the hospital policy.
3. Indication for transfusion is recorded in the patient's medical record.
4. Blood bank staff members receive information about an indication of transfusion, clinical information of the patient, and whether the request is needed on an emergency or routine basis.

Related standards:

ICD.06 Medical patient assessments; ICD.21 Transfusion of blood and blood products; ICD.17 Orders and requests; PCC.07 Patient and family education process

ICD.21 Blood and/or blood components are transfused according to professional practice guidelines.

Safety

Keywords:

Transfusion of blood and blood products

Intent:

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 haemolytic transfusion reactions and other significant morbidities.

All blood transfusion reactions must be immediately reported to the Head of the Blood Bank and Quality Department for prompt investigation of the cause of the adverse reaction.

The hospital shall develop a policy and procedures for the transfusion of blood and/or blood components. The policy addresses at least the following:

- a) Visually check the bag for integrity.
- b) Blood transfusion in emergencies.
- c) Conditions when the bag shall be discarded.
- d) The rate for blood transfusion.
- e) Recording the transfusion.
- f) Monitoring and reporting any adverse event.
- g) Special considerations for the use of blood components.
- h) Management of transfusion complications.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding transfusion of blood and/or blood components.
- GAHAR surveyor may interview involved healthcare professionals especially in inpatient wards, emergency room and procedure areas, to ensure their awareness of hospital policy.
- GAHAR surveyor may observe the process of blood transfusion.
- GAHAR surveyor may review a sample of patients' medical records to check blood transfusion records.

Evidence of compliance:

1. The hospital has an approved policy that describes all elements mentioned in the intent from a) through h).
2. Healthcare professionals involved in blood and/or blood component transfusion are aware of the hospital policy.
3. Blood or blood component bags are visually checked before transfusion.
4. Monitoring of the patient's condition during transfusion is recorded in the patient's medical record.
5. A system is implemented to prevent and manage transfusion complications.

Related standards:

ICD.20 Ordering of blood and blood products; ICD.06 Medical patient assessments.

ICD.22 GSR.10 The hospital has a hospital-wide process for recognition of and response to clinical deterioration.

Effectiveness

Keywords:

Recognition and response to clinical deterioration

Intent:

Early detection of warning signs and provision of urgent care on the right time leads to better functional and long-term outcome than resuscitation of patients with cardio-pulmonary arrest. Studies have shown that this strategy has positive impact on reducing in-hospital mortality and improving patient safety.

The hospital shall develop and implement a policy and procedures to ensure safe process of recognition of and response to clinical deterioration.

The policy addresses at least the following:

- a) Defined criteria for recognition of clinical deterioration.
- b) Education of staff members on the defined criteria.
- c) Identification of involved staff members to respond.
- d) Mechanisms to call staff members to respond, including code(s) that may be used for calling emergency.
- e) The time frame of response.
- f) The response is uniform 24 hours a day and seven days a week.
- g) Recording of response and management.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the safe process of recognition of and response to clinical deterioration.
- GAHAR surveyor may interview involved staff members in direct patient care to ensure their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to check recording observations such as respiratory rate, oxygen saturation, blood pressure, heart rate, temperature, consciousness level, etc. for recognition of clinical deterioration and to check response records.
- GAHAR surveyor may review a sample of staff members' files for those involved in direct patient care to check their training records.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g).
2. All staff members involved in direct patient care are trained on recognition of and response to clinical deterioration.
3. Recognition and response to clinical deterioration are done as per the hospital policy, using age specific criteria.
4. Recognition and response to clinical deterioration are recorded in the patient's medical record.

Related standards:

ICD.06 Medical patient assessments; ICD.07 Nursing patient assessments; CSS.05 Cardiopulmonary resuscitation

Critical and Special Care Services

Chapter intent:

This group of standards focuses on critical and special care services, addressing the unique needs of individuals requiring intensive, specialized, or complex medical care. These standards aim to ensure the provision of high-quality, evidence-based care in settings such as intensive care units (ICUs), cardiac care units (CCUs), neonatal intensive care units (NICUs), and other specialized care units.

Special care services encompass a diverse range of healthcare interventions tailored to address specific medical needs and conditions. These services are designed to provide targeted care and support to individuals requiring specialized treatments and interventions such as hemodialysis, chemotherapy, radiotherapy, childbirth, rehabilitation, and mental health.

This chapter requires establishing and implementing clinical care programs for the critical and special care services available and provided by the hospital. A clinical care program refers to a structured and coordinated approach to healthcare delivery encompassing various components and processes to provide comprehensive and patient-centered care. It is a systematic framework designed to optimize the quality, safety, and effectiveness of healthcare services within a specific area of practice or specialty.

Clinical care programs typically integrate multiple healthcare disciplines and professionals, including physicians, nurses, therapists, pharmacists, and other specialists, who work collaboratively to deliver care to individuals with specific medical conditions or needs. These programs often follow evidence-based guidelines, best practices, and established protocols to ensure standardized and consistent care delivery.

The components of a clinical care program may vary depending on the area of practice and patient population. However, common elements include assessment and diagnosis, treatment planning, care coordination, intervention and treatment delivery, monitoring and evaluation, and patient education and support. Clinical care programs prioritize patient education and support continuous quality improvement by monitoring outcomes and identifying areas for improvement.

Chapter purpose:

The standards of this chapter help to:

- 1) provide a framework for decision-making, and ensure that patients receive comprehensive and coordinated care throughout their journey in critical and special care services.
- 2) Enhance care coordination, improve patient outcomes, optimize resource utilization.
- 3) Promote a consistent standard of care.

CSS Chapter Summary of Changes

Summary of Changes Chapter 5

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
CSS.01 KW: Critical care	ICD.33 KW: Critical care	3) Modified EOC: <ul style="list-style-type: none"> (EOC.01 The hospital has a clinical care program for critical care units that addresses all the elements mentioned in the intent from a) through h). (EOC.04: Management and use of critical care services is done according to clinical guidelines. 4) Rephrased EOCs: (EOC.02, & EOC.05). 5) Added a new EOC: (EOC.03 At least one physician, in each shift, is trained in advanced cardiac life support).
CSS.02 KW: Critical alarms	ICD.34 KW: Critical alarms	1) Modified standard statement: (The hospital has an approved policy and procedures for managing critical medical alarms). 2) Modified EOC: (EOC.01 The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g). 3) Rephrased EOC : (EOC.03 Management and the use of critical alarms are done according to the approved policy). 4) Added a new EOC: (EOC.05 Alarm events and malfunctions are reported, and actions are taken to maintain the safety of clinical alarms).
CSS.03 KW: Catheter and tube misconnections	ICD.35 KW: Catheter and tube misconnections	1) Modified EOC: (EOC.01 The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through e). 2) Rephrased EOC: (EOC.03 Management and use of tubes and catheters are done as per the hospital policy).
CSS.04	ICD.26	1) Modified EOCs:

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
KW: Terminally ill patients	KW: Terminally ill patients	<ul style="list-style-type: none"> • (EOC.01 The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through f). • (EOC.05: Terminally ill patients' assessment, reassessment, and management are recorded in the patient's medical record). <p>2) Rephrasing of EOC: (EOC.03 Terminally ill patients are assessed and receive the appropriate management of symptoms, including pain and depression).</p> <p>3) Added a new EOC: (EOC.04 Patients and family are involved in decisions and care).</p>
CSS.05 KW: Cardiopulmonary resuscitation	ICD.36 KW: emergency equipment and supplies ICD.38 KW: Cardiopulmonary resuscitation and medical emergencies	Updated standard (CSS.05) by merging two standards (ICD.36 and ICD.38) in Hospital edition 2021.
CSS.06 KW: Dialysis services	ICD.32 KW: Dialysis services	<p>1) Modified standard statement: (Dialysis service is provided and managed according to laws, regulations, and clinical guidelines).</p> <p>2) Modified EOC: (EOC.01 The hospital has a clinical care program for dialysis service that addresses all the elements mentioned in the intent from a) through f).</p> <p>3) Added a new EOC: (EOC.02 Staff involved in dialysis service are competent at handling the program.</p> <p>4) Rephrasing of EOCs: (EOC.03, EOC.04 & EOC.05)</p>
CSS.07 KW: Chemotherapy	ICD.31 KW: Chemotherapy and Radiotherapy	4) Modified standard statement: (Chemotherapy service is provided according to laws, regulations, and clinical guidelines/protocols.).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<p>5) Modified EOCs: (EOC.01, EOC.02 & EOC.05).</p> <p>6) Added new EOCs:</p> <ul style="list-style-type: none"> • (EOC.03 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). • (EOC.04 Patients and/or their families are educated on the treatment plan).
CSS.08 KW: Radiotherapy		New standard.
CSS.09 KW: Childbirth	ICD.24 KW: Safe childbirth process	<p>6) Modified standard statement to be: (Childbirth services are provided according to clinical guidelines).</p> <p>7) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.01 The hospital has a childbirth care program addresses all the elements mentioned in the intent from a) through f). • (EOC.05 Assessment, reassessment, plan of care, CTG (cardiotocography), Partogram, pain management, and delivery summary are documented in the patient medical record). <p>8) Added new EOCs:</p> <ul style="list-style-type: none"> • (EOC.02: The healthcare professionals involved in the childbirth are competent in handling the program). • (EOC.03: Pain in women during labor is managed according to pain management protocol).
CSS.10 KW: Rehabilitation.	ICD.22 KW: patient's functional needs	<ul style="list-style-type: none"> • New standard.
CSS.11 KW: Psychiatric disorders	ICD.27 KW: Psychiatric patients	4) Modified standard statement: (Care for patients who are suffering from mental illness is provided according to applicable laws and regulations).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<p>5) Modified EOCs:</p> <ul style="list-style-type: none"> (EOC.01: The hospital has a clinical care program for mental health that addresses all the elements mentioned in the intent from a) through n). (EOC.03: Mental health patients are assessed and managed according to clinical guidelines/protocols). <p>6) Rephrase EOC: (EOC.04: Psychiatric assessment and care plans for outpatients and inpatients are documented in patient medical record).</p>
CSS.12 KW: Restraint and seclusion	ICD.28 KW: Restraint and seclusion	<p>4) Modified standard statement to be: (Restraint and seclusion are used according to defined criteria, laws, and regulations and in a manner that respect patient's rights).</p> <p>5) Modified of (EOC.04).</p>
CSS.13 KW: Drug abuse	ICD.29 KW: victims of drug abuse and addiction	<p>1) Modified standard statement: (Care for patients who are suffering from substance use disorders is provided according to applicable laws and regulations).</p> <p>2) Modified EOC:</p> <ul style="list-style-type: none"> (EOC.01: The hospital has a clinical care program that addresses all the elements mentioned in the intent from a) through i). (EOC.04: Assessment, plan of care, and monitoring of progress are documented in the patient's medical record). <p>3) Rephrasing of EOC: (EOC.03)</p>
CSS.14 KW: Organ/Tissue transplantation	<p>ADD.08 KW: Organ/Tissue donation choice</p> <p>ADD.09 KW: Organ and Tissue Transplantation services</p>	1) Updated standard (CSS.15) by merging two standards (ADD.08 & ADD.09) in Hospital edition 2021.

Critical Care

CSS.01 Critical care services are provided according to laws, regulations, and clinical guidelines.

Effectiveness

Keywords:

Critical care

Intent:

Critical care services address immediate life-threatening conditions where vital organs are at risk of collapse. Using advanced therapeutic, monitoring, and diagnostic technology, these services aim to maintain organ function and stabilize patients for further treatment. Specialized healthcare teams provide these essential services, making critical care units pivotal in acute care hospitals. Critical care services are both costly and limited. When overwhelmed by a sudden surge in patients, these units may lead to canceled surgeries and extended emergency department wait times.

The hospital may have more than one critical care unit, such as an intensive care unit (ICU), a coronary care unit (CCU), a neonatal intensive care unit (NICU), or a pediatric intensive care unit (PICU), depending on its scope and the population it serves.

A clinical care program refers to a structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions according to clinical guidelines and protocols. A clinical care program for intensive care units (ICUs) involves specialized care and management for critically ill patients requiring intensive monitoring and treatment that include the following:

- a) Multidisciplinary team
- b) Admission and discharge criteria
- c) Initial assessment requirements, including circulation, respiration, and oxygenation.
- d) Continuous monitoring and life support.
- e) Care planning and goal setting
- f) Clinical guidelines/protocols that address at least the following items:
 - Resuscitation and stabilization
 - Ventilatory and respiratory support
 - Invasive procedures and interventional techniques
 - Rehabilitation and early mobilization
- g) Nutritional support
- h) Psychosocial support and family engagement, as appropriate.

Survey process guide:

- GAHAR surveyor may review the hospital clinical care program for critical care units.
- GAHAR surveyor may interview the involved healthcare professionals to check their awareness of the hospital program.
- GAHAR surveyor may review a sample of patients' medical records to ensure assessment, plan of care, and monitoring of progress documentation.
- GAHAR surveyor may review critical care unit shift schedules and corresponding physicians' files to ensure the presence of at least one physician trained in advanced cardiac life support on each shift.
- GAHAR surveyor may review a sample of the involved healthcare professionals' files to check their competency assessment.

Evidence of compliance:

1. The hospital has a clinical care program for critical care units that addresses all the elements mentioned in the intent from a) through h).
2. The healthcare professionals involved in critical care are competent in handling the program.
3. At least one physician in each shift is trained in advanced cardiac life support.

4. Management and use of critical care services is done according to clinical guidelines.
5. Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.

Related standards:

ACT.13 Special care units' access; ICD.16 Clinical practice guidelines adaptation and adoption; CSS.02 Critical alarms; ACT.11 Multidisciplinary Management; ICD.15 Plan of Care.

CSS.02 GSR.08 The hospital has an approved policy and procedures for managing critical medical alarms.

Safety

Keywords:

Critical alarms

Intent:

Medical devices, especially those related to vital functions, are fitted with alarms that alert staff members on conditions of device malfunction or patient's critical situation. Losing that function exposes patients to an increased risk of morbidity and mortality. Alarms are intended to induce immediate appropriate action from staff members to either check device malfunction or initiate action that will revert the situation. This can be ensured when all the staff members become fully aware of alarm settings (values and volume) and their significance and are trained on the required actions to be taken when triggered. Annual competency testing for staff members is needed to ensure the safe use of monitors and other devices with critical alarming systems. The hospital shall develop and implement a policy and procedures for the safe management and use of critical alarms. The policy addresses at least the following:

- a. Inventory of critical alarms and their preventive maintenance.
- b. Critical alarms are tested and activated with appropriate settings.
- c. Priorities for competing alarms, staff members authorization for disabling alarms or changing their settings and monitoring of response to alarm activation.
- d. Staff members' responsibility, control measures, and remedial action.
- e. Alarms are sufficiently audible with respect to distances and competing for noise within the unit.
- f. Documentation required, including evidence of responsible staff members, responsible company, schedule, agreed settings, evidence of function.
- g. Reporting malfunction and remedial action.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the safe management and use of critical alarms and also review the inventory of all devices with critical alarms, including setting guidelines.
- GAHAR surveyor may review the schedules of alarm tests and documentation of the currently active settings at different care areas.
- GAHAR surveyor may interview staff around devices with critical alarms to check their knowledge of critical alarm settings and response to their activation, and also interview maintenance staff to check their knowledge of critical alarm settings.
- GAHAR surveyors may observe (listen) or activate critical alarms to check the suitability of the alarm volume for the working space.
- GAHAR surveyor may review maintenance records for evidence of responsible staff, a responsible company, a schedule, agreed-upon settings, evidence of function, reporting of malfunction, and remedial action.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g).
2. Competent individuals are responsible for the management and use of critical alarms.

3. Management and the use of critical alarms are done according to the approved policy.
4. Management and use of critical alarms are recorded according to policy.
5. Alarm events and malfunctions are reported, and actions are taken to maintain the safety of clinical alarms.

Related standards:

CSS.01 Critical care; EFS.10 Medical Equipment Plan; WFM.09 Staff Performance Evaluation

CSS.03 GSR.09 A system is in place 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, or drainage). During care, these tubes and catheters may be misconnected, leading to the administration of the wrong material via the wrong route, resulting in grave consequences.

When purchasing new catheters and tubing, the hospital has documented acceptance testing and risk assessment to identify the potential for misconnections.

The hospital shall develop and implement a policy and procedures guiding the prevention of catheter and tubing misconnections.

The policy addresses at least the following:

- a) Non-clinical staff members, families, or visitors should not be responsible for connecting and disconnecting tubes.
- b) Labelling of high-risk catheters (e.g., arterial, epidural, intrathecal) and avoidance of using catheters with injection ports for these applications.
- c) Tracing of all lines from their origin to the connection port to verify attachments before making any connections or reconnections or administering medications, solutions, or other products.
- d) Standardized line reconciliation, rechecking process, and catheter maps as part of handover communications.
- e) Acceptance testing and risk assessment to identify potential misconnections when purchasing new catheters and tubing.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding catheter and tubing misconnection prevention.
- GAHAR surveyor may interview responsible staff members to describe the catheter and tubing connection processes.
- GAHAR surveyor may review a sample of patients' medical records to check the management and use of tubes and catheters records and the safe tube connection use monitoring record presence.
- GAHAR surveyor may review a sample of responsible staff files to check their competency assessment.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through e).
2. Competent individuals are responsible for the management and use of tubes and catheters.
3. Management and use of tubes and catheters are done as per the hospital policy.

4. Management and use of tubes and catheters are recorded in patient medical records.

Related standards:

ACT.08 Handover communication; OGM.10 Supply Chain Management.

CSS.04 Terminally ill patients' needs are assessed and managed.

Patient-centeredness

Keywords:

Terminally ill patients

Intent:

Following a critical illness, many patients experience a diminished and shortened quality of life. Aggressive interventional treatments often cause significant pain and distress, potentially extending the dying process rather than preserving life. When the burdens of such treatments outweigh the benefits, transitioning to palliative care may be in the patient's best interest. Palliative care prioritizes symptom management, psychosocial support for patients and families, and alignment of treatments with individual goals, values, and preferences.

In the final days or hours of life, therapeutic goals should shift to focus on comfort and dignity, withdrawing interventions that do not contribute to these aims. Symptom relief for pain, dyspnea, anxiety, and agitation should be managed with carefully titrated medications based on explicit assessments. The needs of patients and families to attend to dying patients should be met as much as possible, with religious expertise sought if appropriate.

The hospital shall develop and implement a policy and procedures for the assessment, reassessment, and management of the terminally ill patient population. The policy addresses at least the following:

- a) Principles of palliative and end-of-life care.
- b) Patient-centered care tailored to individual needs, preferences, values, and goals.
- c) Shared decision-making with the involvement of the patient and/or family.
- d) Pain management of end-of-life care.
- e) Provision of patient and family counselling and support for psychosocial, emotional, cultural, and spiritual needs.
- f) The multidisciplinary team approach, including healthcare professionals, caregivers, and patients and their families.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding assessment, reassessment, and management of the terminally ill patient population.
- GAHAR surveyor may interview responsible staff members to ensure their awareness of the hospital policy.
- GAHAR surveyor may interview the terminally ill patients' families to ensure their involvement in decisions and care.
- GAHAR surveyor may review a sample of patients' medical records to check assessment, reassessment, and management documentation.
- GAHAR surveyor may review a sample of responsible staff files to check their competency assessment.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through f).

2. Competent individuals are responsible for the assessment and management of terminally ill patients.
3. Terminally ill patients are assessed and receive the appropriate management of symptoms, including pain and depression.
4. Patients and family are involved in decisions and care.
5. Terminally ill patients' assessment, reassessment, and management are recorded in the patient's medical record.

Related standards:

PCC.12 Patient's needs; PCC.13 Patient's dignity, privacy, and confidentiality; PCC.07 Patient and family education process; ICD.06 Medical patient assessments.

CSS.05 GSR.11 Response to cardio-pulmonary arrest in the hospital is managed for both adult and pediatric patients.

Effectiveness

Keywords:

Cardiopulmonary resuscitation

Intent:

Any patient receiving care within a hospital 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, trained staff members, at least on basic life support, should be available during working hours and ready to respond to any emerging situation. All the time, availability of adequate and functioning equipment and supplies is also a cornerstone for resuscitating patients in emergency conditions.

The hospital shall develop and implement a policy and procedures to ensure safe management of cardio-pulmonary arrests.

The policy addresses at least the following:

- a) Defined criteria for recognition of cardio-pulmonary arrest, including adults and pediatrics.
- b) The required qualifications and advanced life support training of the hospital code teams.
- c) Education of staff members on the defined criteria.
- d) Identification of involved staff members who will respond.
- e) Mechanisms for calling staff members to respond, including code(s) that may be used for calling an emergency.
- f) The time frame of response.
- g) The response is uniform 24 hours a day and seven days a week.
- h) Recording of response and management.
- i) Management of emergency equipment and supplies, including:
 - i. Identification of required emergency equipment and supplies list according to laws, regulations, and standards of practice.
 - ii. Emergency equipment and supplies are available throughout the hospital and checked daily for readiness.
 - iii. Emergency equipment and supplies are age-appropriate.
 - iv. Emergency equipment and supplies are replaced immediately after use or when expired or damaged.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the safe management of cardio-pulmonary arrests and interview involved staff members to ensure their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to check cardio-pulmonary arrest management records.

- GAHAR surveyor may review the files of involved staff members to check their qualifications and training records.
- GAHAR surveyors may assess the availability and functionality of age-appropriate emergency equipment, medications, and supplies throughout the hospital.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through i).
2. All staff members involved in cardiopulmonary resuscitation are aware of the hospital policy.
3. Staff with basic life support start the process immediately, while those with advanced life support will start within a maximum of 5 minutes.
4. Age-appropriate emergency equipment, medications, and supplies are available throughout the hospital.
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.

Related standards:

ICD.22 Recognition and response to clinical deterioration; CCS.01 Critical care; MMS.05 Emergency Medications.

Specialized Care

CSS.06 Dialysis service is provided and managed according to laws, regulations, and clinical guidelines.

Effectiveness

Keywords:

Dialysis services

Intent:

Dialysis is a life-sustaining treatment for individuals with end-stage kidney disease (ESKD) or severe kidney dysfunction. It serves as a renal replacement therapy.

A clinical care program refers to a structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions.

The hospital shall develop and implement a clinical care program to ensure the safe and effective use of dialysis service that addresses at least the following:

- a) Pre-dialysis assessment
- b) National/ international clinical guidelines defining:
 - i. Dialysis modality selection based on the assessment of an individual's condition.
 - ii. The timing of initiation of dialysis is based on clinical manifestations and lab workup.
 - iii. Vascular access management to ensure optimal dialysis delivery.
 - iv. Prevention and management of dialysis-induced complications.
 - v. Cardiopulmonary collapse and urgent medical conditions during dialysis.
 - vi. Infection control precautions.
 - vii. Patient immunization according to laws and regulations.
- c) Close monitoring of the patient during dialysis sessions.
- d) Medication management to control chronic complications of end-stage renal disease and dialysis.
- e) Periodic laboratory testing and clinical assessment to optimize dialysis prescription.
- f) Patient education and support, including dietary and fluid management.

Survey process guide:

- GAHAR surveyor may review the hospital clinical care program for safe and effective use of dialysis service.
- GAHAR surveyor may interview involved staff members to ensure their awareness.
- GAHAR surveyor may review a sample of patients' medical records to check assessment, plan of care, and monitoring of progress documentation.
- GAHAR surveyor may review a sample of involved staff members' files to check their competency assessment.
- GAHAR surveyor may review dialysis services' registers concerning patients' monitoring of viral markers at regular intervals to detect seroconversion.

Evidence of compliance:

1. The hospital has a clinical care program for dialysis service that addresses all the elements mentioned in the intent from a) through f).
2. Staff involved in dialysis service are competent at handling the program.
3. Management and use of dialysis services are done according to clinical guidelines.
4. Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.
5. Monitoring viral markers at regular intervals to detect and manage seroconversion according to laws, regulations, and clinical guidelines.

Related standards:

ICD.06 Medical patient assessments; ICD.16 Clinical practice guidelines adaptation and adoption; ICD.15 Plan of Care.

CSS.07 Chemotherapy service is provided according to laws, regulations, and clinical guidelines/protocols.

Effectiveness

Keywords:

Chemotherapy

Intent:

Chemotherapy is a drug treatment that uses powerful chemicals to kill fast-growing cells in the body. Chemotherapy is most often used to treat cancer since cancer cells grow and multiply much more quickly than most cells in the body; it may be given by mouth, injection, infusion, or on the skin, depending on the type and stage of the cancer being treated. Chemotherapy drugs can destroy all types of healthy blood cells and harm the body's production of new ones.

A clinical care program refers to a structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions.

The hospital shall develop and implement a clinical care 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 hospital clinical care 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 hospital has a clinical care 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.

Related standards:

ICD.06 Medical patient assessments; ICD.16 Clinical practice guidelines adaptation and adoption; ICD.15 Plan of Care; PCC.07 Patient and family education process.

CSS.08 Radiotherapy service is provided according to laws, regulations, and clinical guidelines/protocols.

Effectiveness

Keywords:

Radiotherapy

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. This non-invasive treatment approach can be employed as a primary treatment, used alongside surgery or chemotherapy, or as palliative care to relieve pain and improve quality of life.

A clinical care program refers to a structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions.

The hospital shall develop and implement a clinical 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, during which precise imaging techniques are used to map the treatment area.
- c) Radiation treatment delivery, including external and internal radiation therapy.
- d) Processes to verify the accuracy of treatment plans, radiation doses, and treatment delivery and adherence to strict safety protocols.
- e) Accurate patient positioning and immobilization techniques are critical for precise radiation delivery. Immobilization devices, such as molds, masks, or customized cradles, may be used to minimize patient movement.
- f) Optimization measures needed to achieve the required therapeutic effect using the effective radiation dose to the targeted organ with fewer radiation hazards.
- g) Provision of all possible safety measures for releasing patients after radionuclide therapy, particularly for family members and the general public.
- h) Proactive management of side effects to minimize their impact and maximize patient comfort.
- i) Patient and/or family education and support.
- j) Regular monitoring and assessment to evaluate treatment response and adjust the treatment plan if necessary.

Survey process guide:

- GAHAR surveyor may review the hospital clinical care program for safe and effective use of radiotherapy.
- GAHAR surveyor may interview involved healthcare professionals to ensure their awareness.
- 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.
- GAHAR surveyor may review a sample of involved staff members' files to check their competency assessment.

Evidence of compliance:

1. The hospital has a clinical care program for radiotherapy service that addresses all the elements mentioned in the intent from a) through j).
2. The healthcare professionals involved in the radiotherapy service are competent in handling the program.
3. Management and use of radiotherapy services are done according to laws and regulations.
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.

CSS.09 Childbirth services are provided according to clinical guidelines.

Safety

Keywords:

Childbirth

Intent:

It is vital to comply with evidence-based essential birth practices to improve both maternal and neonatal health. The WHO Safe Childbirth Checklist (SCC) is a facility-based reminder tool focusing on necessary care to improve intrapartum care quality. Each of the practices included within the checklist has its own evidence base, including effectiveness in improving maternal outcomes, improving neonatal outcomes, or both.

The checklist included 28 evidence-based practices organized into 4 pause points: on admission, just before pushing or CS, soon after birth, and before discharge from the facility. Each item on the checklist is an essential action or practice that targets major causes of maternal deaths, intrapartum-related stillbirths, and neonatal deaths that occur in facilities around the world.

A clinical care program refers to a structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions.

The hospital shall develop and implement a clinical care program to ensure safe and effective childbirth service that addresses the following:

- a) Assessment and re-assessment of women in labor,
- b) Use of cardiotocography and partogram for women in labor.
- c) Clinical guidelines/protocol that address the following items:
 - Management of premature rupture of membranes.
 - Management of Antepartum hemorrhage.
 - Management of fetal distress.
 - Induction of labor.
 - Episiotomy.
 - Instrumental vaginal delivery.
 - Caesarean section (CS), repeated CS, and emergency hysterectomy.
 - Management of multiple births.
 - Management of post-partum hemorrhage.
- d) Management of pain in women in labor.
- e) The immediate postpartum care.
- f) Providing support for breastfeeding and newborn care.

Survey process guide:

- GAHAR surveyor may review the hospital clinical care program for safe and effective childbirth services.
- GAHAR surveyor may interview involved healthcare professionals to ensure their awareness.
- GAHAR surveyor may review a sample of patients' medical records to assess compliance with the standard requirements.
- GAHAR surveyor may review a sample of involved healthcare professionals' files to check their competency assessment.

Evidence of compliance:

1. The hospital has a childbirth care program that addresses all the elements mentioned in the intent from a) through f).

2. The healthcare professionals involved in the childbirth are competent in handling the program.
3. Pain in women during labor is managed according to pain management protocol.
4. Checklists or other tools are used successfully for every delivery.
5. Assessment, reassessment, plan of care, CTG (cardiotocography), Partogram, pain management, and delivery summary are documented in the patient's medical record.

Related standards:

ICD.06 Medical patient assessments; ICD.07 Nursing patient assessments; ICD.16 Clinical practice guidelines adaptation and adoption; WFM.09 Staff Performance Evaluation

CSS.10 Rehabilitation services are provided according to professional practice guidelines.

Patient-centeredness

Keywords:

Rehabilitation

Intent:

Rehabilitation, often referred to as rehab, is a comprehensive and multidisciplinary approach aimed at helping individuals recover, regain functionality, and improve their overall well-being after an injury, illness, or surgery. It involves a range of medical, therapeutic, and supportive interventions designed to address physical, cognitive, emotional, and social aspects of a person's health. Examples of rehabilitation services provided in hospitals may include but are not limited to Physiotherapy, Occupational Therapy, Speech Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation, Neurological Rehabilitation, etc.

The primary goal of rehabilitation is to restore or enhance an individual's ability to perform daily activities, maximize their independence, and improve their quality of life. Rehabilitation programs are tailored to the specific needs and goals of everyone, considering their unique circumstances, medical conditions, and functional limitations.

The hospital shall develop and implement policy(s) and procedures to be used by each rehabilitation module provided by the hospital and include at least the following:

- a. The types of rehabilitation programs and services offered within the hospital, including inpatient, outpatient, and long-term hospital rehabilitation.
- b. Qualified staff is responsible for overseeing the provision of each rehabilitation service according to patient needs.
- c. The use of professional standards of practices to guide the rehabilitation interventions that include at least:
 - i. Assessment and evaluation of the individual's condition, abilities, and goals. This involves medical evaluations by the physiatrist, physical and functional assessments, and psychological evaluations.
 - ii. Plan of care, based on the medical and functional assessment, to address the individual's specific needs and goals.
 - iii. Multidisciplinary team of healthcare professionals who collaborate to provide comprehensive care.
 - iv. Designing a patient-oriented treatment program with clear medical problem lists and the goals of the rehabilitation program.
 - v. Education and counseling to help individuals and their families understand the condition, cope with the challenges, and make informed decisions regarding their care.
 - vi. Regular monitoring of the individual's progress.

- d. Rehabilitation equipment and resources to facilitate the rehabilitation process, such as exercise machines, assistive devices, mobility aids, and adaptive technologies.
- e. Discharge planning and follow-up care to ensure a smooth transition from the program to a suitable setting. This may involve arranging for home modifications, recommending community resources and support services, and coordinating with other healthcare providers to ensure continuity of care.
- f. Medical records documentation requirements for each module.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding rehabilitation services.
- GAHAR surveyor may interview staff members providing rehabilitation services to ensure their awareness.
- GAHAR surveyor may review a sample of patients' medical records to check assessment, plan of care, monitoring of progress, discharge planning, and follow-up care documentation.
- GAHAR surveyor may observe the alignment of the utilized rehabilitation therapies with the required rehabilitation type.
- GAHAR surveyor may review a sample of involved staff members' files to check their qualifications.

Evidence of compliance:

1. The hospital has a rehabilitation policy(s) that addresses all the elements mentioned in the intent from a) through f).
2. Staff providing rehabilitation services are aware of the components of the policies related to the services provided.
3. Rehabilitation therapies are employed based on the type of rehabilitation required.
4. Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.
5. Discharge is planned, and follow-up care is done.

Related standards:

ICD.06 Medical patient assessments; ICD.16 Clinical practice guidelines adaptation and adoption; ICD.08 Screening for further assessment needs; ICD.15 Plan of Care.

CSS.11 Care for patients who are suffering from mental illness is provided according to applicable laws and regulations.

Patient-centeredness

Keywords:

Psychiatric disorders

Intent:

People living with mental health conditions deserve to be treated with dignity and respect, and they are entitled to rights and protections under various laws and regulations. Mental health services encompass a wide range of interventions and support systems designed to promote and maintain mental well-being, prevent mental health disorders, and provide treatment and care for individuals experiencing mental health challenges.

These services are provided by a dedicated team of mental health professionals, including psychiatrists, psychologists, therapists, counselors, and social workers.

A clinical care program refers to a structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions.

Hospital having a psychiatry department, unit, or clinic shall establish and implement a clinical care program to ensure safe and effective mental health services that address the following:

- a) Assessment and evaluation of the individual's mental health condition.
- b) Screening, assessment, and management of patient's risk of imminent harm to self and others
- c) Safe and appropriate use of behavioral restraint and seclusion.
- d) A personalized treatment plan that may include various modalities and care coordination for complex cases that need multiple treatment providers.
- e) Psychotherapy and counseling, such as cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), psychodynamic therapy, or interpersonal therapy.
- f) Medication management, including appropriate prescribing, regular monitoring of medication effectiveness and side effects, and coordination between mental health providers and primary care physicians if necessary.
- g) Group therapy and support as an adjunct to individual therapy.
- h) Rapid tranquilization provision and administration guided by evidence-based practices and guidelines.
- i) Use of electroconvulsive therapy (ECT).
- j) Suicide prevention approaches
- k) Provisions for crisis intervention and psychiatric emergency services to ensure appropriate and timely responses to urgent situations.
- l) The involvement of family members or other support systems in the treatment process.
- m) Discharge planning includes transitioning individuals to lower levels of care, coordinating follow-up appointments, providing relapse prevention strategies, and ensuring appropriate community-based support services are in place.
- n) Performance measures to monitor, assess, and improve the program.

Survey process guide:

- GAHAR surveyor may review the hospital clinical care program for safe and effective mental health services
- GAHAR surveyor may interview responsible staff members to ensure their awareness.
- GAHAR surveyor may review a sample of patients' medical records to check psychiatric assessment and care plan documentation for both outpatients and inpatients.
- GAHAR surveyor may review a sample of involved staff members' files to check their competency assessment.

Evidence of compliance:

1. The hospital has a clinical care program for mental health that addresses all the elements mentioned in the intent from a) through n).
2. Competent individuals are responsible for the assessment and management of mental health patients.
3. Mental health patients are assessed and managed according to clinical guidelines/protocols.
4. Psychiatric assessment and care plans for outpatients and inpatients are documented in the patient's medical record.

Related standards:

ICD.06 Medical patient assessments; ICD.16 Clinical practice guidelines adaptation and adoption; ICD.08 Screening for further assessment needs; ICD.15 Plan of Care; CSS.12 Restraint and seclusion; CSS.13 Drug abuse.

CSS.12 Restraint and seclusion are used according to defined criteria, laws, and regulations and in a manner that respects the patient's rights.

Patient-centeredness

Keywords:

Restraint and seclusion

Intent:

Coercion, defined as the use of intervention against a person's will, is a globally important issue. In psychiatry, coercive measures often involve limiting freedom of movement to contain aggressive behavior but are also used in other medical contexts. Coercion raises ethical and legal questions by limiting fundamental human rights such as liberty, autonomy, and physical integrity, thus requiring strict regulation.

Determining the clinical effects of coercion is challenging due to ethical, legal, and methodological concerns. Despite limited evidence of effectiveness, coercive measures are commonly used, particularly in psychiatry. These interventions should be a last resort, with patients' preferences considered. Enhancing the therapeutic relationship could improve the outcomes and perception of coercion.

The hospital shall develop and implement a policy and procedures for appropriate and safe use of restraint and seclusion. The policy addresses at least the following:

- a) The use of restraints or seclusion is according to defined criteria, laws, and regulations.
- b) Requirements for clear physician order for the use of restraints and seclusion.
- c) Safe and effective application and removal by qualified staff members.
- d) The least restrictive methods are to be used as appropriate.
- e) Protection of patient's rights, dignity, and well-being during use.
- f) Monitoring and reassessment during use.
- g) Renewal of the restraint order is based on continuing needs and according to laws and regulations.
- h) Management and care for patient's needs during restraint and seclusion.
- i) Termination of restraints and seclusion is according to defined criteria.

Survey process guide:

- GAHAR surveyor may review the hospital policy for appropriate and safe use of restraint and seclusion.
- GAHAR surveyor may interview involved staff members to ensure their awareness.
- GAHAR surveyor may review a sample of patients' medical records to check restraint and seclusion records.
- GAHAR surveyor may review a sample of involved staff members' files to check their competency assessment.
- GAHAR surveyor may observe to ensure compliance with the hospital policy.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through i).
2. All staff members involved in restraint and seclusion are aware of the hospital policy.
3. Competent individuals are responsible for the use of restraint and seclusion.
4. Restraint and seclusions are used as per the policy.
5. Restraints and seclusions are recorded in the patient's medical record.

Related standards:

ICD.06 Medical patient assessments; PCC.13 Patient's dignity, privacy, and confidentiality; ICD15 Plan of Care; CSS.11 Psychiatric disorders.

CSS.13 Care for patients who are suffering from substance use disorders is provided according to applicable laws and regulations.

Patient-centeredness

Keywords:

Drug abuse

Intent:

Victims of drug abuse and addiction face significant physical, psychological, and social consequences resulting from their substance use. The services provided to these individuals aim to address their unique needs, promote recovery, and improve overall well-being. These services are typically delivered through a comprehensive and multidisciplinary approach involving healthcare professionals, counselors, social workers, and peer support networks.

A clinical care program refers to a structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions.

Hospital having a department, unit, or clinic for addiction management shall develop and implement a clinical care program for victims of drug abuse and addiction that addresses the following:

- a) Assessment and diagnosis.
- b) Medically supervised detoxification: this involves providing necessary medications, monitoring vital signs, and ensuring a supportive and safe environment during the withdrawal period.
- c) Counselling and psychotherapy: evidence-based therapies, such as cognitive-behavioral therapy (CBT), motivational interviewing, and contingency management, are often used.
- d) Medication-assisted treatment (MAT).
- e) Supportive Services: this may include case management, vocational support, educational assistance, housing support, peer support groups, and family therapy.
- f) Dual Diagnosis Treatment addressing both addiction and underlying mental health issues simultaneously through integrated care.
- g) Relapse prevention.
- h) Peer Support and Aftercare.
- i) Continuum of Care by providing resources for aftercare, follow-up appointments, and ongoing support services to maintain long-term recovery.

Survey process guide:

- GAHAR surveyor may review the hospital clinical care program for victims of drug abuse and addiction.
- GAHAR surveyor may interview responsible staff members to ensure their awareness.
- GAHAR surveyor may review a sample of patients' medical records to check assessment, plan of care, and monitoring of progress documentation.
- GAHAR surveyor may review a sample of responsible staff members' files to check their competency assessment.

Evidence of compliance:

1. The hospital has a clinical care program that addresses all the elements mentioned in the intent from a) through i).
2. Competent individuals are responsible for the assessment and management of victims of drug abuse and addiction patients.
3. Victims of drug abuse and addiction patients are assessed and managed according to clinical guidelines/protocols.
4. Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.

Related standards:

ICD.16 Clinical practice guidelines adaptation and adoption; ICD.06 Medical patient assessments; PCC.13 Patient's dignity, privacy, and confidentiality; ICD15 Plan of Care; CSS.11 Psychiatric disorders.

CSS.14 Human organ and tissue transplant services are performed according to applicable laws, regulations, and clinical guidelines.

Equity

Keywords:

Organ/Tissue transplantation

Intent:

Organ and tissue transplantation services represent a lifeline for countless individuals suffering from severe organ failure, offering hope for renewed life and the chance to embrace a brighter future. The World Health Assembly has endorsed a set of guiding principles addressing ethical aspects of organ transplantation, such as voluntary and unpaid donation, as well as the issues of universal access to transplant services and the availability, safety, and quality of the procedures. Efforts need to be made to ensure the banning of organ trafficking and transplant tourism.

The hospital should promote donations motivated by the needs of the recipient and the community's benefit. However, all practices to encourage the procurement of cells, tissues, and organs for transplantation should be defined explicitly. Any measures to encourage donation should respect the dignity of the donor and foster societal recognition of the nature of cell, tissue, and organ donation.

The hospital shall develop and implement a clinical care program to provide the highest standard of care, ensuring the successful and ethical practice of transplantation. The program encompasses every facet of the transplant journey, from patient evaluation and donor management to post-transplant and long-term follow-up. The program should include at least the following:

- a) Criteria for selecting suitable organ and tissue transplant candidates, including medical, psychological, and social considerations.
- b) Comprehensive pre-transplant evaluation of recipients, including medical history, physical examinations, laboratory tests, and imaging studies.
- c) Clinical guidelines/protocol that address the following items:
 - i. Protocols for identifying suitable donors, evaluating donor health and compatibility, and ensuring ethical organ and tissue procurement practices.
 - ii. Transplant Surgery Procedures.
 - iii. Immunosuppression and Anti-Rejection Strategies.
 - iv. Management of complications that may arise during and after transplantation.
 - v. Guidelines for post-operative care, including monitoring for complications, infections, and rejection.
 - vi. Infection control measures to minimize the risk of post-transplant infections.
- d) Ethical and legal considerations, including informed consent and the donor-recipient relationship. Live donors should be informed in a complete and understandable fashion of the probable risks, benefits, and consequences of donation.
- e) Establish an ethics committee to review challenging cases and ethical dilemmas that may arise in the transplantation process.
- f) Psychosocial and social support for patients and their families throughout the transplantation process.
- g) Education and training for healthcare professionals involved in the transplant program.
- h) Address specific considerations for transplantation in children, elderly patients, and individuals with special medical conditions.
- i) Assess the success and outcomes of transplantation procedures, including graft survival rates and patient outcomes.

Survey process guide:

- GAHAR surveyor may review the hospital clinical care program for human organ and tissue transplant services.
- GAHAR surveyor may interview the involved healthcare professionals to ensure their awareness of the hospital program.
- GAHAR surveyor may review a sample of patients' medical records to check pre-transplantation evaluation and post-transplantation care documentation.
- GAHAR surveyor may review a sample of involved healthcare professionals' files to check their competency assessment.
- GAHAR surveyor may interview a donor to ask about the information given concerning the risks, benefits, and consequences of donation.

Evidence of compliance:

1. The hospital has a clinical care program that addresses all the elements mentioned in the intent from a) through i).
2. The healthcare professionals involved in the organ and tissue transplant are competent in handling the program.
3. The hospital has a committee overseeing organ and tissue donation activities through regular meetings.
4. Pre-transplantation evaluation and post-transplantation care plan are recorded in the patient's medical record.
5. The hospital assesses the success and outcomes of transplantation procedures, including graft survival rates and patient outcomes.

Related standards:

ICD.06 Medical patient assessments; PCC.08 Informed consent; ICD15 Plan of Care; ICD.16 Clinical practice guidelines adaptation and adoption; OGM.15 Ethical Management

Diagnostic and Ancillary Services

Chapter intent:

Patients consult physicians to assess and manage their health concerns. In many cases, a diagnosis can be established through a thorough medical history and physical examination. However, diagnostic tests, such as laboratory work or imaging, are often required to provide additional information.

The scope of this chapter covers the following diagnostic and ancillary services.

Diagnostic Imaging:

- Radiological Imaging
- Ultrasound
- Mammography
- Nuclear medicine
- Magnetic resonance imaging (MRI)
- Computed tomography (CT)
- Echocardiography
- Bone densitometry

Laboratory Medicine:

- Sample collection
- Chemistry and Immunology
- Microbiology
- Hematology
- Anatomic pathology and cytology
- Molecular Biology
- Cytogenetics
- Point-of-care testing - Transfusion medicine
- IVF laboratories

There are generally three phases in the process of diagnostic investigation:

1. Before doing the investigation: comprises the time and all processes for the preparation of a patient for a diagnostic investigation to the moment when the investigation is performed.
2. During doing the investigation: comprises the time and all processes of a diagnostic investigation.
3. After doing the investigation: The post-analytical phase comprises the time and all processes for reporting the results of the diagnostic investigation to the person who then provides care to the patient.

Made errors during each phase influence the clinical relevance of a diagnostic report, and precautions should be taken to avoid results that are misleading or provide false information. The diagnostic services familiarizes the clinician with the value of the information obtained from an investigation, including its diagnostic specificity. This requires constant communication between clinical staff and the diagnostic service. Diagnostic reports are valuable only when the information can be used for patient management. It is, therefore, an obligation for the diagnostic service to provide the results to the clinician in a timely manner so that the results can be interpreted together with the clinical findings for the patient.

The chapter also covers blood transfusion services as one of the critical ancillary services. The quality and safety of blood and blood products should be assured and traced throughout the process from the selection of blood donors to the administration of blood to the patient or safe disposal of the blood/ blood component.

GAHAR surveyors may be focusing on the communication of the patient information to ensure correct and effective patient management plans. The accuracy and precision of the results reported to clinicians are one of the main targets of the survey together with the safety of the

patients, staff, and facility since significant organization hazards are present in these areas, whether biological, chemical, radiological or others.

Chapter purpose:

The main objective is to ensure that the hospital provides diagnostic services and blood bank service safely and effectively; that is why the chapter discusses the following objectives:

1. Safe and effective medical imaging services.
2. Safe and effective clinical laboratory and pathology services.
3. Safe and effective blood transfusion services

DAS chapter Summary of changes

Summary of Changes Chapter 6

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
DAS.01 KW: Planning medical imaging services	DAS.01 KW: Planning medical imaging services	<ol style="list-style-type: none"> 1) Modified standard statement (Medical Imaging and ancillary services are planned, operated, and provided according to laws and regulations). 2) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: Medical Imaging or ancillary services provided either onsite or through accredited outside source meet laws, regulations, and applicable guidelines). • (EOC.03: The hospital ensures the quality and safety of outsourced medical imaging and ancillary services). • (EOC.04: Medical imaging and ancillary services provided are evaluated annually).
DAS.02 KW: Provision of medical imaging service	DAS.02 KW: Provision of medical imaging service	<ol style="list-style-type: none"> 1) Modified standard statement: (Medical imaging and ancillary services are performed by competent healthcare professionals according to applicable laws and regulations). 2) Added a new EOC: (EOC.02: Licensed healthcare professionals are providing medical image services). 3) Modified EOC: (EOC.03: Privileges are granted for performing each intervention medical imaging service based on assessed competencies).
DAS.03 KW: Technical standards (Practice Parameters)	DAS.03 KW: Technical standards (Practice Parameters)	<ol style="list-style-type: none"> 1) Modified standard statement: (Performance of medical imaging studies and procedures and ancillary services is standardized).
DAS.04 KW: Pre-examination process	DAS.04 KW: Pre-examination process	<ol style="list-style-type: none"> 1) Modified standard statement: (There is a process in place for medical imaging and ancillary services' pre-examination). 2) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy and procedures to guide the medical imaging and ancillary services pre-examination process that includes elements from a) to e) in the intent. • (EOC.03 & EOC.04).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
DAS.05 KW: Medical imaging quality assurance and control	DAS.05 KW: Medical imaging quality assurance and control	4) Updated (EOC.03) by merging two EOCs (EOC.03 & EOC.04) in Hospital edition 2021.
DAS.06 KW: Medical imaging examination protocols	DAS.06 KW: Medical imaging examination protocols	1) Modified standard statement: (Medical imaging and ancillary services examination protocols are available and followed). 2) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: Medical imaging protocols are available and address element from a) to d) in the intent). • (EOC.02: Medical imaging staff members are trained on medical imaging protocols). • (EOC.04: Imaging protocols for pediatric patients are optimized to obtain the required imaging data while delivering the lowest radiation dose possible).
DAS.07 KW: Medical imaging reports	DAS.07 KW: Medical imaging reports	1) Modified EOC: (EOC.01: The hospital has an approved policy that addresses all elements mentioned in the intent from a) through e). 2) Updated (EOC.04) by merging two EOCs (EOC.04 & EOC.05) in Hospital edition 2021.
DAS.08 KW: Medical imaging results	DAS.08 KW: Medical imaging results	1) Modified standard statement: (Copies of medical imaging or ancillary results are recorded in the patient's medical record). 2) Modified EOCs: (EOC.01, EOC.02 & EOC.03).
DAS.09 KW: Radiation Safety Program.	DAS.09 KW: Radiation Safety Program	1) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has a written, updated, and approved radiation safety program that addresses all elements mentioned in the intent from a) through h). • (EOC.03: The hospital ensures that exposed patients do not exceed the approved maximum level). 2) Added new EOCs: <ul style="list-style-type: none"> • (EOC.04: Environmental radiation safety measures, personal monitoring devices results, and the regular CBC results are available and documented).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<ul style="list-style-type: none"> • (EOC.05: Nuclear medicine safety measures are implemented by addressing the elements from i) through v) in the intent). • (EOC.06: Laser safety measures are implemented by addressing the elements from I) to III) in the intent).
DAS.10 KW: Laboratory services planning and management.	DAS.10 KW: Laboratory services planning and management.	1) Modified EOC: (EOC.04: The scope of service is periodically reviewed and modified whenever a clinical service is added, modified, or deleted). 2) Updated (EOC.05) by merging two EOCs (EOC.05 & EOC.06) in Hospital edition 2021.
DAS.11 KW: Laboratory Staff	DAS.11 KW: Laboratory Staff	1) Modified EOC: (EOC.03: Laboratory work is scheduled and processed based upon the competencies assessed).
DAS.12 KW: Reagent Management	DAS.12 KW: Reagent Management	1) Rephrasing of standard statement to be: (The hospital has a process to manage reagents and other laboratory supplies). 2) Modified EOC: (EOC.01 The hospital has an approved policy that addresses all the mentioned elements from a) through e) in the intent). 3) Added new EOCs: <ul style="list-style-type: none"> • (EOC.02: The laboratory staff is aware of hospital policy). • (EOC.05 :Reagents and supplies utilization are accurately monitored).
DAS.13 KW: Outsourced laboratory services	DAS.13 KW: referral laboratory	6) Rephrasing of standard statement to be: (The hospital has a process to select and monitor outsourced laboratory services).
DAS.14 KW: Pre-examination process	DAS.15 KW: Pre-examination process	4) Rephrasing of standard statement to be: (The hospital has a process for laboratory pre-examination.) 5) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy to guide the pre-examination process that includes elements from a) to i) in the intent). • (EOC.03: All staff involved in requesting laboratory tests and collection of samples are aware of the pre-examination policy).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
DAS.15 KW: Specimen reception, tracking and storage.	DAS.16 KW: Specimen reception, tracking and storage.	<ol style="list-style-type: none"> 1) Rephrasing of standard statement to be: (The hospital has a process for specimen reception, tracking, and storage). 2) Modified EOC (EOC.06: Samples are stored in appropriate conditions during all examination activities).
DAS.16 KW: Verified / Validated test methods.	DAS.17 KW: Verified / Validated test methods.	<ol style="list-style-type: none"> 1) Modified EOC (EOC.01: The laboratory has an approved policy that describe the process for verification/validation of examination methods for all laboratory tests). 2) Added a new EOC (EOC.02: The involved laboratory staff is aware of hospital policy).
DAS.17 KW: Examination procedures	DAS.18 KW: Examination procedures	<ol style="list-style-type: none"> 1) Rephrasing of standard statement to be: (Instructions for performing test methods and procedures are followed). 2) Modified EOC (EOC.01: the laboratory has a written updated procedure for each analytical test method).
DAS.18 KW: Laboratory Internal quality assessment	DAS.19 KW: Laboratory Internal quality assessment	<ol style="list-style-type: none"> 1) Modified standard statement: (An internal quality control process is developed and implemented for all tests). 2) Modified EOC (EOC.01: The hospital has an approved procedure describing the internal quality control process of all laboratory tests addressing all elements in the intent from a) through g). 3) Updated (EOC.05) by merging two EOCs (EOC.05 & EOC.06) in Hospital edition 2021.
DAS.19 KW: Laboratory external quality assessment	DAS.20 KW: Laboratory external quality assessment	<ol style="list-style-type: none"> 1) Rephrasing of EOC: (EOC.01: The laboratory subscribes to an external proficiency-testing program that consider the scope and complexity of tests performed by the laboratory).
DAS.20 KW: Post examination process	DAS.21 KW: Post examination process	<ol style="list-style-type: none"> 1) Modified EOCs: <ul style="list-style-type: none"> (EOC.01: The hospital has an approved policy to guide the post-examination process that include all elements mentioned in the intent from a) through f). (EOC.05: The procedure of specimen storage, retention and disposal is implemented).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		2) Added a new EOC (EOC.02 : The laboratory staff is aware of hospital policy).
DAS.21 KW: Laboratory turnaround time	DAS.22 KW: Laboratory turnaround time	1) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has a process defining each laboratory test's total turnaround time and means of measuring it.) • (EOC.04: Delays in turnaround time are notified to requestors/end-user.) 2) Updated (EOC.03) by merging two EOCs (EOC.04 & EOC.05) in Hospital edition 2021.
DAS.22 KW: STAT results	DAS.23 KW: STAT results	1) Rephrasing of standard statement to be: (STAT results are reported within the defined timeframe). 2) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has a process to guide ordering, collection, testing, and results reporting of urgent tests). • (EOC.04: The hospital monitors the reported data on STAT turnaround time and takes actions to control or improve the process as appropriate).
DAS.23 KW: Laboratory Safety Program.	DAS.24 KW: Laboratory Safety Program.	1) Modified EOC (EOC.01 : A written updated program that describes safety measures for laboratory services and facilities is documented and includes the items in the intent from a) to j). 2) Rephrasing of EOC (EOC.06 : The hospital monitors the reported data on laboratory safety program and takes actions to control or improve the process as appropriate).
DAS.24 KW: Point of care testing	DAS.25 KW: Point of care testing	1) Rephrasing of (EOC.02). 2) Added a new EOC (EOC.03 : The hospital identifies all POCT sites, and the testing performed).
DAS.25 KW: Blood Transfusion services management	DAS.26 KW: Blood Transfusion services management	1) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: There is an approved manual that addresses all elements mentioned in the intent from a) through k). • (EOC.02: All blood bank staff members are aware of the contents of the manual).
DAS.26	DAS.27	1) Modified EOCs:

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
KW: Safe blood donation	KW: Safe blood donation	<ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy that describes all elements mentioned in the intent from a) through e). • (EOC.03: Blood donors are selected according to the hospital policy).
DAS.27 KW: Blood Procurement	DAS.28 KW: Blood Procurement	1) Modified standard statements: (Processes of collection, handling, testing of blood, and blood components are performed according to national/international requirements).
DAS.28 KW Blood Storage	DAS.29 KW: Blood Storage	1) Modified EOCs: <ul style="list-style-type: none"> • (EOC.04: Blood and/or blood components are stored under access-controlled and recorded temperature-controlled conditions). • (EOC.06: Expired blood or blood components are managed according to guidelines).
DAS.29 KW: Contracted blood banks	DAS.30 KW: Contracted blood banks	1) Modified standard statement: (The hospital has a process to select and inspect outsourced blood and blood components).
DAS.30 KW: Blood Transfusion services management	DAS.32 KW: Blood Transfusion services management	1) Rephrasing of standard statement to be: (The hospital has a process to ensure safe distribution of blood and/or blood components). 2) Added a new EOC (EOC.03: Blood sample label and blood transfusion request are completed with all required data and cross-checked before issuing blood or blood components).

Medical Imaging

Efficient planning and management of radiological services

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

Efficiency

Keywords:

Planning medical imaging services

Intent:

Medical Imaging is a cornerstone of any hospital. An efficient, high-quality, medical imaging service increases patient satisfaction as a result of its ability to improve patient care. Over time, the service adds significant patient's volumes to the hospital. The location of medical imaging is important for easy access by emergency patients, ambulant patients, inpatients, and different functional areas.

Special attention 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.

Medical Imaging services being expensive, and complex are selected and agreed upon by the hospital leaders according to a study of the needs of the hospital that may dynamically change from one year to another, thus continuous evaluation is required. The hospital should plan and design a system for providing medical imaging services required by its patient population, clinical services offered, and healthcare practitioner needs.

Ancillary services include all electrograms as ECG; EMG and EEG as well as all functional studies as bone densitometry; micturition flowmeter and oesophageal manometry, optical coherence tomography (OCT)... Etc.

The hospital 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, adopting suitable quality expectations and professional standards.

When a medical imaging or an ancillary service is provided outside the designated radiology service area; as MRS or PET CT if not found or under maintenance, it should follow the same protocols, guidelines, and safety procedures as the hospital main radiology imaging and ancillary service area. The medical imaging and ancillary services should meet national laws, regulations, and applicable guidelines.

Survey process guide:

- GAHAR surveyor may learn about the provision of medical imaging and ancillary services through the hospital orientation session, licenses and permits may be reviewed during environment and facility plans evaluation session.
- GAHAR surveyor may visit areas where medical imaging and ancillary services are provided including radiology department or other departments where portable medical imaging and ancillary services are provided.
- GAHAR surveyor may review contractual agreements and related reports during financial stewardship review session or during leadership interview session.

Evidence of compliance:

1. Medical Imaging or ancillary services provided either onsite or through accredited outside source meet laws, regulations, and applicable guidelines.
2. Medical Imaging list of services meets the scope of clinical services of the hospital.
3. The hospital ensures the quality and safety of outsourced medical imaging and ancillary services.
4. Medical imaging and ancillary services provided are evaluated annually.

Related standards:

DAS.03 Technical standards (Practice Parameters), EFS.01 Hospital environment and facility safety management, OGM.13 Contract Management

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

Efficiency

Keywords:

Provision of medical imaging service

Intent:

Medical imaging and ancillary services professionals are vital members of a multidisciplinary team that forms a core of highly trained healthcare professionals, who each bring expertise to the area of patient care. They also play a critical role in the delivery of health services as new modalities emerge and the need for medical imaging and ancillary services procedures increase within the laws and regulations.

Medical imaging and ancillary services integrate 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 and ancillary services professionals remain 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 and ancillary services professionals participate in quality improvement processes and continually assess their professional performance.

When Medical Imaging and ancillary services are provided on-site at the hospital they are managed by a healthcare professional who is qualified by education and training consistent with applicable laws and regulations.

The medical imaging services develops 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) Assessment of problem-solving skills.
- e) 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 intervention 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 emergency situations.

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

Related standards:

DAS.03 Technical standards (Practice Parameters), OGM.09 Departmental management, WFM.05 Verifying credentials, WFM.09 Staff Performance Evaluation , WFM.04 Job Description , WFM.08 Continuous Education Program, WFM.12 Clinical Privileges

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

Effectiveness

Keywords:

Technical standards (Practice Parameters)

Intent:

Medical imaging and ancillary services encompass 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 or ancillary service 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 study types. The technical medical imaging or ancillary 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 hospital develops and implements procedures for medical imaging to ensure safety and usability of modalities. For each modality, procedure manual addresses 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 the procedure manual for each study type.
- GAHAR surveyor may interview medical imaging staff members to check their awareness on procedure manual for each study type.
- GAHAR surveyor may visit areas where medical imaging or ancillary services are provided including radiology department or other departments where these services are provided to assess compliance with standard requirements.

Evidence of compliance:

1. The medical imaging service has a written procedure for each study type.
2. Procedure manuals are readily available in the medical imaging department. Each procedure includes all the required elements from a) through f) in the intent.
3. Staff are trained of the contents of procedure manuals.
4. The procedures are consistently followed.

Related standards:

DAS.01 Planning medical imaging services, WFM.08 Continuous Education Program, EFS.10 Medical Equipment Plan, WFM.07 Orientation Program, DAS.05 Medical imaging quality assurance and control.

Effective operational processes of medical imaging

DAS.04 There is a process in place for medical imaging and ancillary services' pre-examination.
Effectiveness

Keywords:

Pre-examination process

Intent:

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

Medical imaging or ancillary 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 medical imaging service develops and implements a pre-examination policy and procedures 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 patient information (patient identification, date of birth, gender, and patient contact), name of the ordering physician, studies requested, date and time of study, clinical information, highlighting 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 or ancillary pre-examination policy during document review session.
- GAHAR surveyor may trace a patient receiving a medical imaging or any ancillary services and review service request, patient preparation and service manual.
- GAHAR surveyor may interview nurses and other healthcare professionals to check their awareness on preparation requirements.
- GAHAR surveyor may visit areas where medical imaging services are provided including radiology department or other departments where portable medical imaging services are provided to check request review, patient identification process and communication with referrers and patients.

Evidence of compliance:

1. The hospital has an approved policy and procedures to guide the medical imaging and ancillary services pre-examination process that includes elements from a) to e) in the intent.
2. Clinicians are provided with information regarding the merits of the various diagnostic imaging techniques.
3. Medical imaging or ancillary services staff members ensure that a patient performs pre-examination, review of requests, and verify patient identity.
4. Medical imaging or ancillary service staff member ensures that a 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.
6. When an additional or substituted examination is called for, medical imaging diagnostic service staff member informs patients and referrers and document it in patient's medical record.

Related standards:

ICD.17 Orders and requests, PCC.07 Patient and family education process, IMT.08 Patient's Medical record Management , ACT.03 Patient identification , WFM.08 Continuous Education Program

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

Effectiveness

Keywords:

Medical imaging quality assurance and control

Intent:

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 and helps the medical imaging service to determine accuracy of images.

Management of the routine quality control (QC) of medical imaging equipment is a major responsibility of the medical imaging professionals. 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, analysis, followed up and preventive actions are taken and recorded before major problems arise.

The medical imaging service develops and implements a procedure for quality control that include at least the following:

- a) Elements of the quality control performed according to guidelines, manufacturer instructions for each study/modality.
- b) The frequency for quality control testing is determined by the hospital according to guidelines and 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 identified through quality control measures.

Survey process guide:

- GAHAR surveyor may visit areas where medical imaging services are provided including radiology department or other departments where portable medical imaging services are provided to check 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 hospital 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 and recorded.
4. Responsible authorized staff member reviews quality control function and checks data at least monthly.
5. Corrective action is taken whenever targets are unmet.

Related standards:

DAS.03 Technical standards (Practice Parameters), EFS.10 Medical Equipment Plan, WFM.08 Continuous Education Program, OGM.09 Departmental management

DAS.06 Medical imaging and ancillary services examination protocols are available and followed.

Safety

Keywords:

Medical imaging examination protocols

Intent:

Medical imaging or ancillary service shall develop documented professional supervision protocols for the performance of imaging examinations under the professional supervision of the clinical radiologist staff member. Documented imaging protocols shall be available and include all necessary information for the proper conduct of the examination, considering any specifications for the required qualifications, experience, and specialization of the healthcare professionals.

Medical imaging service or ancillary protocols ensure that, when it is known that the clinical radiologist staff member is not available to provide appropriate additional input for modalities or examinations, as detailed in the protocols, the medical imaging team members do not proceed with an examination. The hospital shall ensure that examinations requiring sedation of the patient are not undertaken unless an appropriately trained medical staff member is available to personally attend the patient, and the safety requirements are met.

These protocols should cover:

- a) Radiographic or examination factors
- b) Positioning,
- c) Aftercare according to the relevant examinations and/or modalities performed at the service.
- d) These protocols shall also address medical emergencies.

Imaging protocols for paediatric patients shall be optimized to obtain the required imaging data while delivering the lowest radiation dose possible and with minimal use of sedation and anaesthesia.

Survey process guide:

- GAHAR surveyor may review medical imaging examination protocols.
- GAHAR surveyor may trace and observe a patient receiving a medical imaging service and review positioning, radiographic factors, or aftercare processes.

- GAHAR surveyor may interview medical imaging staff members to check their awareness on examination protocols.
- GAHAR surveyor may visit areas where medical imaging services are provided including radiology department or other departments where portable medical imaging services are provided to observe medical imaging equipment, setup, and modalities.

Evidence of compliance:

1. Medical imaging protocols are available and address element from a) to d) in the intent.
2. Medical imaging staff members are trained on medical imaging protocols.
3. Examinations requiring sedation of the patient are not undertaken unless an appropriately trained medical staff member is available to immediately attend the patient, and the safety requirements are met.
4. Imaging protocols for paediatric patients are optimized to obtain the required imaging data while delivering the lowest radiation dose possible.

Related standards:

DAS.03 Technical standards (Practice Parameters), WFM.08 Continuous Education Program, ICD.16 Clinical practice guidelines adaptation and adoption

DAS.07 Medical Imaging findings 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 is sent back to the referring medical staff member.

The hospital develops and implements a policy and procedures to guide the process of reporting medical imaging investigations that addresses at least the following:

- a) Time frames for reporting various types of images to healthcare professional and to patients.
- b) Emergency and routine reports.
- c) Accountabilities on the medical Imaging reports across the hospital.
- d) Qualified licensed medical staff member is responsible for interpretation and reporting.
- e) The medical imaging service shall have an implemented process for notifying the referrer when a study or report is delayed.

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 nurses, medical imaging service staff members and other healthcare professionals to inquire about their experience regarding medical imaging service reporting time.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through e).
2. Staff members involved in interpreting and reporting results are competent to do so.
3. Results are reported within approved timeframe.
4. The hospital monitors the reported data on reporting time for medical imaging services and takes actions to control or improve the process as appropriate.
5. Delays in reporting medical imaging studies are notified to referrers.

Related standards:

ICD.19 Critical results, QPI.06 Clinical Performance Measures, QPI.12 Sustaining Improvement, WFM.06 Staff Files, WFM.12 Clinical Privileges

Safe medical imaging studies

DAS.08 Copies of medical imaging or ancillary results are recorded in the patient's medical record.

Safety

Keywords:

Medical imaging results

Intent:

The written medical Imaging or ancillary 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:

- a) The hospital name.
- b) Patient identifiers on each page.
- c) Type of the investigation.
- d) Results of the investigations.
- e) Time of reporting.
- f) Name and signature of the reporting radiologists.

Survey process guide:

- GAHAR surveyor may perform patient's medical record review and assess completion of medical imaging service reports.
- GAHAR surveyor may interview nurses, medical imaging service staff members and other healthcare professionals to inquire about report completion requirements and actions to be taken in case of incomplete reports.

Evidence of compliance:

1. There is a process to complete medical imaging and ancillary reports that addresses all elements mentioned in the intent from a) through f).
2. All medical imaging and ancillary staff involved in result reporting are trained on the required elements.
3. Complete medical imaging and ancillary studies are recorded in the patient's medical record.
4. When reports are not complete, there is a process to inform reporting radiologists.

Related standards:

IMT.08 Patient's Medical record Management, ACT.03 Patient identification.

DAS.09 GSR.12 Radiation safety program is developed and implemented.

Safety

Keywords:

Radiation Safety Program.

Intent:

Radiation safety program ensures all activities with ionizing and non-ionizing radiation are conducted in a safe manner and in compliance with the law and regulations, and applicable standards and guidelines.

The program is administered by the Radiation Safety Officer and is designed to protect staff, patients, and the public from potential exposure to radiation from radioactive sources and radiation-emitting devices. Furthermore, the radiation safety program controls the release of radioactive materials into the environment. The program shall maintain that all radiological equipment is used safely.

The hospital 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 hospital shall develop and implement a radiation safety program that addresses all components of the radiological services. It should be properly communicated to all staff, implemented, reviewed, and updated annually. The program shall include at least the following:

- a) Availability and applicability of the staff self-monitoring tools.
- b) Availability and applicability of the suitable personal protective equipment.
- c) Patients' radiation safety precautions.
- d) Methods to ensure that patients who receive ionizing radiation doses (e.g. CT or in catheter units) are not exceeding the international references of the International Atomic Energy Agency (IAEA).
- e) All ionizing and non- ionizing radiation equipment are maintained and calibrated.
- f) MRI safety program, which includes pre-exposure screening for metals, metallic implants, devices, and use of MRI compatible devices.
- g) Nuclear medicine and PET CT radiation protection and safety measures:
 - i. Safe waste disposal and isolated sewage for radioactive materials according to national law and regulations.
 - ii. Safe hot lab for radioisotope processing.
 - iii. Isolated waiting area for injected patients.
 - iv. Each area in the nuclear medicine unit is labelled and isolated.
 - v. The Survey meter and dose calibrator must be calibrated.
- h) Laser safety measures:
 - I. Laser safety PPEs
 - II. Non-refractive surface in the installed room
 - III. Laser warning signs

Survey process guide:

- GAHAR surveyor may review the radiation safety program to check the approved level of exposure according to local laws and regulations, shielding methods, and safety requirements.
- GAHAR surveyor may review environmental radiation measures, thermos-luminescent dosimeter (TLD), and/or badge films of the staff results, CBC results, lead aprons inspection.
- GAHAR surveyor may interview staff to check their awareness.
- GAHAR surveyor may observe the implemented radiation safety measures.

Evidence of Compliance:

1. The hospital has a written, updated, and approved radiation safety program that addresses all elements mentioned in the intent from a) through h).
2. Staff members involved in medical imaging are aware of the radiation safety program.
3. The hospital ensures that exposed patients do not exceed the approved maximum level.
4. Environmental radiation safety measures, personal monitoring devices results, and the regular CBC results are available and documented.
5. Nuclear medicine safety measures are implemented by addressing the elements from i) through v) in the intent.
6. Laser safety measures are implemented by addressing the elements from I) to III) in the intent.

Related standards:

EFS.01 Hospital environment and facility safety management, EFS.07 Safety Management Plan , EFS.10 Medical Equipment Plan, OGM.17 Staff Health program , WFM.08 Continuous Education Program, CSS.08 Radiotherapy

Clinical Laboratory

Appropriate planning and management

DAS.10 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 ensure 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 hospital systems.

The hospital develops and implements a management and technical system for providing laboratory services required by its patient population, offered clinical services, and healthcare professional needs as well as hospital mission.

The laboratory scope of services is required to be enlisted and available for patients, hospital staff, and healthcare professionals. The designated area should fulfil the following:

- Is physically separate from other activities in the hospital.
- Accommodate all laboratory activities.
- Aligned with the mission and serving the hospital's population flow.
- Dedicated area for collection of samples.

Survey process guide:

- GAHAR surveyor may visit the laboratory area(s) as part of a patient tracer or hospital 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 guidelines, standards of practice, laws, and regulations.
2. Laboratory services are available to meet the needs related to the hospital mission and patient population.

3. Scope of service is defined and documented in the hospital Laboratory.
4. The scope of service is periodically reviewed and modified whenever a clinical service is added, modified, or deleted.
5. The designated laboratory area is available and separate from any other activities, including a dedicated area for sample collection.

Related standards:

EFS.01 Hospital environment and facility safety management, OGM.02 Mission Statement, OGM.09 Departmental management

DAS.11 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 develops a policy and procedures describing the performance evaluation 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, interlaboratory 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 certain 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 competency assessment policy during document review session.
- GAHAR surveyor may interview laboratory and HR leaders to inquire about competence assessment methods, frequency and granting privileges.
- GAHAR surveyor may review laboratory services to compare work rooster with the competencies assessed.

Evidence of compliance:

1. The hospital has an approved policy and procedure that address all the mentioned elements from a) through e) in the intent.
2. Competency assessment is performed annually and recorded in laboratory staff file.
3. Laboratory work is scheduled and processed based upon the competencies assessed.

Related standards:

OGM.09 Departmental management, WFM.05 Verifying credentials, WFM.09 Staff Performance Evaluation, WFM.04 Job Description, WFM.02 Staffing Plan, WFM.12 Clinical Privileges

DAS.12 The hospital has a process to manage reagents and other laboratory supplies.

Effectiveness

Keywords:

Reagent Management

Intent:

Managing laboratory reagents and supplies is important for reducing substantial costs and ensuring a high quality of reagents as direct contributors to test results. It also enables laboratory management to run the laboratory efficiently and increase productivity.

The hospital shall develop and implement a policy and procedures that guide the process of management of laboratory reagents and other supplies that includes at least the following:

- a) Criteria for inspection, acceptance, and rejection of provided reagent.
- b) Methods of identification, enlisting and labelling of all reagents present in the laboratory.
- c) Measures to ensure that the laboratory does not use expired materials.
- d) Define safety limits for the reordering of the laboratory materials according to the laboratory needs.
- e) Requesting, issuing, and dispatching reagent and supplies as well as identifying responsible person.

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session.
- GAHAR surveyor may review the list of reagents and other supplies and observe their storage, labelling, use, expiration and quality check processes.
- GAHAR surveyor may review stock levels and consistency between the physical inventory and recorded inventory.
- GAHAR surveyor may interview laboratory staff to check their awareness about inspection, acceptance or rejection criteria of reagents and other supplies.
- GAHAR surveyor may review reagent and supplies requested, issued, and dispatched

Evidence of compliance:

1. The hospital has an approved policy that addresses all the mentioned elements from a) through e) in the intent.
2. The laboratory staff is aware of hospital policy.
3. The laboratory has an inventory for all reagents and supplies that are used for all testing processes.
4. Reagents and other supplies are inspected and accepted or rejected based on approved criteria.
5. Reagents and supplies utilization are accurately monitored.
6. Reagents are requested, issued, and dispatched effectively.

Related standards:

OGM.11 Stock Management, OGM.10 Supply Chain Management, DAS.17 Examination procedures , DAS.18 Laboratory Internal quality assessment

DAS.13 The hospital has a process to select and monitor outsourced laboratory services.

Efficiency

Keywords:

Outsourced 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 or contracted lab.

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 to assure the quality of performance. The hospital has a policy and procedures to control the outsourced laboratory services that includes:

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 to contract, 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. Turnaround Time (TAT)
- v. Result reporting
- vi. Release of information to the third party
- vii. Mean of solving disputes
- viii. The validity of the agreement and review schedule.

Survey process guide:

- GAHAR surveyor may review hospital policy during document review session, and review referral laboratory agreement and results during financial stewardship session or leadership interview session.
- 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 hospital 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 viii).
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 the compliance.

Related standards:

OGM.13 Contract Management

Effective operational processes in the laboratory

DAS.14 The hospital has a process for laboratory pre-examination.

Effectiveness

Keywords:

Pre-examination process

Intent:

Pre-examination processes is 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 a pre-examination policy that include all needed information for the patient and laboratory staff for at least the following:

- a) Proper completion of request form to include patient information (patient identification, date of birth, gender, and patient contact), name of the ordering physician, tests requested, date and time of specimen collection, identification of the person who collected the specimen, clinical information, type of specimen (source of specimens), 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 labelling.
- e) Criteria for safe disposal of materials used in the collection.
- f) Proper handling and transportation of specimens.
- g) Turnaround time of tests
- h) Minimal retesting Interval
- i) Individual test precaution

The document shall provide an overview for the laboratory service, containing information about the laboratory to the patient and shall explain all information they need regarding the pre-examination phase.

This document 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 during document review session.
- GAHAR surveyor may trace a patient receiving a laboratory service and review service request, patient preparation and service manual.
- GAHAR surveyor may interview nurses and other healthcare professionals to check their awareness on pre-examination requirements.
- GAHAR surveyor may visit areas where laboratory services area to check request review, patient identification process, communication with requestors and patients, specimen collection preparation, specimen labelling, handling and transportation of specimens.

Evidence of compliance:

1. The hospital has an approved policy to guide the pre-examination process that includes elements from a) to i) in the intent.

2. There is a laboratory service manual distributed to all users and available in all technical areas.
3. All staff involved in requesting laboratory tests and collection of samples are aware of the pre-examination policy.
4. Preparation of specimen collection and labelling requirements are implemented.
5. Specimens are handled and transported safely.

Related standards:

ICD.17 Orders and requests, DAS.17 Examination procedures, PCC.07 Patient and family education process, DAS.21 Laboratory turnaround time, DAS.22 STAT results, ACT.03 Patient identification, WFM.08 Continuous Education Program

DAS.15 The hospital 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 labelling to specimen reception, analysis, and storage, to significantly allow workers to identify the specimen location, history, and status.

The hospital develops and implements 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 hospital policy during document review session followed by interviewing staff members to inquire about their awareness of hospital policy.
- GAHAR surveyor may visit the laboratory to review records of received and rejected specimens and match reasons for rejection with approved criteria.
- GAHAR surveyor may also review laboratory specimen identification, traceability process and storage.
- GAHAR surveyor may review records of specimens referred to other laboratories.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements in the intent from a) through e).

2. All laboratory 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:

DAS.17 Examination procedures, IMT.02 Information management plan , ACT.03 Patient identification

DAS.16 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 driving 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 hospital 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 and records the results obtained and the staff with the appropriate authority reviews the result and records the review.

Whenever applicable, 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:

- d) Using a non-standard method.
- e) The standard method used outside its intended scope.
- f) The validated method with modification.

The laboratory shall follow verification/validation methods endorsed by reliable and updated guidelines. Reverification/ Revalidation is conducted and documented whenever needed e.g., periodic, major changes in verified/validated examination procedure, and after major failures.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding the verification/validation of the examination methods for all tests provided by the laboratory, and evidence of staff member training and competency records, followed by interviewing laboratory staff members to inquire

about their awareness of hospital policy, their competence and knowledge of the introduced or changed tests.

- GAHAR surveyor may review verification/ validation and reverification/ revalidation records.

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 involved laboratory staff is aware of hospital policy.
3. The laboratory follows verification/validation methods endorsed by guidelines.
4. Records of verification and /or validation results fulfils acceptable criteria based on predetermined guidelines.
5. There is recorded evidence of reverification/revalidation.

Related standards:

DAS.17 Examination procedures, WFM.08 Continuous Education Program

DAS.17 Instructions for performing test methods and procedures are followed.

Effectiveness

Keywords:

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. It 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. Criteria for acceptability and rejection of the sample.
- c) Reagents and equipment used.
- d) Verification/validation of examination procedures.
- e) The test procedure, including test calculations and interpretation of results.
- f) Calibration and control procedures and corrective actions to take when calibration or control results fail to meet the laboratory's criteria for acceptability.
- g) Biological reference intervals/clinical decision values.
- h) Critical test results.
- i) Analytical measurement range and instructions for determining results when it is not within the measurement interval.
- j) Limitations in methodologies including interfering substances.
- k) References.

Survey process guide:

- GAHAR surveyor may review laboratory technical procedures.
- GAHAR surveyor may interview laboratory staff members to check their awareness of analytic procedures.
- GAHAR surveyor may trace and observe a patient undergoing a laboratory service and review preparation processes.
- 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 updated procedure for each analytical test method.
2. The laboratory procedures are readily available when needed.
3. Each procedure includes all the required elements from a) through k) in the intent.
4. Staff are trained and knowledgeable of the contents of procedure manuals.
5. The procedures are consistently followed.

Related standards:

DAS.14 Pre-examination process, DAS.12 Reagent Management, DAS.16 Verified / Validated test methods , DAS.18 Laboratory Internal quality assessment , ICD.19 Critical results , DAS.15 Specimen reception, tracking and storage , WFM.08 Continuous Education Program

DAS.18 An internal quality control process is developed and implemented for all tests.

Effectiveness

Keywords:

Laboratory Internal quality assessment

Intent:

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.

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

The laboratory develops and implements a procedure for internal quality control that shall include at least the following:

- a) Elements of the internal quality control.
- b) The frequency for quality control testing is determined by the hospital according to guidelines and manufacturer instructions whichever is more stringent.
- c) 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.
- d) 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.
- e) Acceptance/ rejection rules for internal quality control results.
- f) Quality Control data is reviewed at a regular interval (at least monthly) by responsible authorized staff member.
- g) Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

Survey process guide:

- GAHAR surveyor may visit laboratory to check quality control procedures, records, documented regular review of the quality control data and the action taken for Outliers or trends.
- GAHAR surveyor may interview laboratory staff members to check their awareness on quality control performance.

Evidence of compliance:

1. The hospital has an approved procedure describing the internal quality control process of all laboratory tests addressing all elements in the intent from a) through g).
2. Laboratory staff members involved in internal quality control are competent in internal quality control performance.
3. All quality control processes are performed according to the internal quality control procedure.
4. All quality control processes are recorded.
5. Responsible authorized staff member reviews quality control process and checks data at least monthly, and corrective action is taken when indicated.

Related standards:

DAS.17 Examination procedures, DAS.12 Reagent Management, WFM.08 Continuous Education Program, OGM.09 Departmental management

DAS.19 External quality assessment program or its alternatives is developed and implemented.

Effectiveness

Keywords:

Laboratory external quality assessment

Intent:

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

It provides a measure for individual laboratory quality and “state of the art” for a test, it supplements internal quality control procedures, it obtains consensus values when true values are unknown and it acts as an educational stimulus to improvement in performance.

External quality testing can identify performance problems not identified by internal quality control systems and helps the laboratory determine how its results compared with those of other laboratories that use the same methodologies.

The laboratory should 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.

The laboratory shall test proficiency specimens according to a written protocol and submits results back to the proficiency-testing provider within the required time.

Samples shall be tested along with the laboratory’s regular patient testing workload by staff members who routinely perform the laboratory test(s) using routine methods.

The laboratory shall not send samples to another laboratory for analysis.

Review of returned results includes the following:

- a) When results are graded and returned, the laboratory director or a designated supervisor shall review the report and documents the review.
- b) Remedial action is recorded for any single or multiple challenges of each analyte that does not fall within acceptable limits.
- c) The results are used for education, re-education, or training of one or more employees when indicated.

The laboratory shall consistently analyze and report results. Records for test handling, examination, and reporting results are retained for at least two years.

When there is no proficiency testing available, the laboratory performs interlaboratory comparison, according to guidelines, with an accredited lab, and the results are recorded at least semi-annually.

Survey process guide:

- GAHAR surveyor may visit laboratory to check external quality control procedures.
- GAHAR surveyor may review records of participation in an external quality assessment program for at least two years including the documented reviewing of laboratory director or a designated supervisor.
- GAHAR surveyor may review the analysis records that does not fall within acceptable limits and the related remedial action taken.
- GAHAR surveyor may interview laboratory staff members to check their awareness on external quality control performance.
- GAHAR surveyor may review procedure and records of alternative proficiency testing whenever no available proficiency testing.

Evidence of compliance:

1. The laboratory subscribes to an external proficiency-testing program that consider the scope and complexity of tests performed by the laboratory.
2. Evidence that the samples are tested along with the laboratory's regular patient testing workload by staff members who routinely perform the laboratory test(s) using routine methods.
3. The laboratory is consistent in testing and reporting results within the required timeframe.
4. A review of returned reports includes the requirements of elements a) through c) in the intent.
5. Records of all processes, including testing, reporting, review, conclusions, and actions, are retained for at least two years.
6. Evidence of proficiency testing alternative procedure is used according to guidelines, whenever no proficiency testing is available.

Related standards:

DAS.17 Examination procedures, OGM.13 Contract Management, OGM.09 Departmental management

DAS.20 Laboratory post-examination process is developed and implemented to ensure accurate reporting and release of verified laboratory tests.

Effectiveness

Keywords:

Post examination process

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 and clearly.

The hospital develops and implements a policy and procedures for post examination process that includes at least the following:

- a) Final report data fulfilment 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, where appropriate, advisory, or explanatory comment when needed.
- b) Reviewing, verifying, and reporting of results by authorized staff member
- c) Criteria for specimen storage.
- d) The defined retention time of laboratory results
- e) The defined retention time of patient samples
- f) Specimens' disposal.

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy to guide the post-examination process that include all elements mentioned in the intent from a) through f).
2. The laboratory staff is aware of hospital policy.
3. The laboratory defines the authorized staff member who review and release the patient's results.
4. The retention process of a final laboratory report is implemented with easy retrieval.
5. The procedure of specimen storage, retention and disposal is implemented.
6. Required specimens are easily retrieved.

Related standards:

IMT.08 Patient's Medical record Management, ACT.03 Patient identification, ICD.19 Critical results

DAS.21 Laboratory results are reported within the acceptable turnaround time.

Timeliness

Keywords:

Laboratory turnaround time

Intent:

Turnaround Time (TAT) is a crucial metric in medical laboratory. It refers to the total amount of time that elapses from the moment a specimen (such as a blood sample, tissue biopsy, or any other material) is collected from a patient until the results of the analysis or testing are reported to the requesting healthcare provider or end-user. TAT is typically measured in hours or days, depending on the nature of the test and the laboratory's workflow.

The laboratory shall have a process for measuring turnaround times and shall assign responsible laboratory staff member for measuring and monitoring it. The process includes means to ensure that turnaround times are acceptable. When turnaround times for one or more tests are unacceptable, laboratory leaders evaluate the data and, when necessary, the testing process and act to either modify the testing and reporting process or set more reasonable turnaround times.

The laboratory shall have an implemented process for notifying the requester when testing is delayed.

Survey process guide:

- GAHAR surveyor may trace a patient receiving a laboratory service and review service request, sample time, test time and reporting time.
- GAHAR surveyor may perform patient's medical record review and assess laboratory result report time.
- GAHAR surveyor may interview nurses, medical staff members and other healthcare professionals to inquire about their experience regarding laboratory service reporting time.
- GAHAR surveyor may check the process and records of notification of delays in turnaround time.

Evidence of compliance:

1. The hospital has a process defining each laboratory test's total turnaround time and means of measuring it.
2. Cases of unacceptable turn-around time are investigated, and proper actions are taken accordingly.
3. The hospital monitors the reported data on reporting times for laboratory tests and takes actions to control or improve the process as appropriate.
4. Delays in turnaround time are notified to requestors/end-user.

Related standards:

ICD.19 Critical results, DAS.22 STAT results, QPI.06 Clinical Performance Measures, QPI.12 Sustaining Improvement, DAS.20 Post examination process.

DAS.22 STAT results are reported within the defined timeframe.

Safety

Keywords:

STAT results

Intent:

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 processes to meet the needs of its customers for rapid test and improve turn-around time of emergency samples with the aim of reaching quicker diagnosis. The laboratory process for urgent samples shall address the four main parts to the STAT testing process. ordering, collection, testing, and results reporting.

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.

Survey process guide:

- GAHAR surveyor may trace an urgent request and observe sample time, test time and reporting time.
- GAHAR surveyor may perform patient's medical record review and check previous urgent patient results and assess laboratory result report time.
- GAHAR surveyor may interview nurses, medical staff members and other healthcare professionals to inquire about their experience regarding STAT laboratory service reporting time.
- GAHAR surveyor may check the process and records of notification of delays in STAT turnaround time.

Evidence of compliance:

1. The hospital has a process to guide ordering, collection, testing, and results reporting of urgent tests.

2. The laboratory has a STAT List of tests with acceptable STAT reporting time for each laboratory test is defined.
3. Cases of unacceptable STAT turn-around time are investigated, and proper actions are taken accordingly.
4. The hospital monitors the reported data on STAT turnaround time and takes actions to control or improve the process as appropriate.
5. Delays in STAT turnaround time are notified to requestors.

Related standards:

QPI.06 Clinical Performance Measures, QPI.12 Sustaining Improvement, DAS.21 Laboratory turnaround time, DAS.20 Post examination process.

Safe laboratory services

DAS.23 GSR.13 A comprehensive documented laboratory safety program is implemented.

Safety

Keywords:

Laboratory Safety Program

Intent:

The laboratory environment can be a hazardous place to work.

Laboratory staff members are 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 were 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 communicated to all staff, implemented, reviewed, and updated annually. 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, (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, labelling and waste disposal process.
- GAHAR surveyor may interview laboratory staff to inquire about their experience regarding Safety Program.

Evidence of compliance:

1. A written updated 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 semi-annually to the hospital 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 hospital monitors the reported data on laboratory safety program and takes actions to control or improve the process as appropriate.

Related standards:

EFS.01 Hospital environment and facility safety management, EFS.07 Safety Management Plan, EFS.10 Medical Equipment Plan, OGM.17 Staff Health program, WFM.08 Continuous Education Program, EFS.06 Hazardous materials safety and waste management, PC.05 PPE guidelines, Physical Barriers, QPI.09 Risk Management Program, QPI.05 Performance Measures, QPI.12 Sustaining Improvement.

Effective Point of care testing

DAS.24 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 and approach to POCT to ensure that it is performed safely and correctly and that the results generated are accurate and reliable.

The hospital 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:

- During tracers and tours, 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. A competent staff member is responsible for performing POCT.
3. The hospital 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.17 Examination procedures, EFS.10 Medical Equipment Plan, WFM.08 Continuous Education Program

Blood Transfusion Services

Efficient planning and management of blood bank

DAS.25 Blood transfusion services are planned, operated, and provided uniformly according to applicable laws, regulations, and clinical guideline /protocol.

Efficiency

Keywords:

Blood Transfusion services management

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 of blood use.

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
- k) Handling of shortage of blood

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.

The hospital may ask the help of a multidisciplinary blood transfusion committee to develop evidence-based transfusion policies, participate in professional education, monitor blood and blood components use and review blood bank reports.

Survey process guide:

- GAHAR surveyor may review the blood bank manual and visit areas where blood banking and transfusion occur as part of a patient tracer or hospital tour. During these visits, Surveyor may check space, design, environment, equipment, and supplies to ensure safe blood transfusion process.
- GAHAR surveyor may review the blood transfusion manual and committee if available.
- 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 k).
2. All blood bank staff members are aware of the contents of the manual.
3. Blood transfusion services have suitable space, environment, equipment, and supplies.
4. Blood transfusion services are monitored by a licensed qualified medical staff member.

Related standards:

DAS.26 Safe blood donation, EFS.01 Hospital environment and facility safety management, EFS.10 Medical Equipment Plan, WFM.05 Verifying credentials, WFM.04 Job Description, OGM.09 Departmental management

Effective operational processes of blood transfusion service

DAS.26 Blood 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 hospital develops and implements a policy and procedures for donors' selection and retention.

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 behaviours and self-exclusion for patient safety, tests carried out on donated blood and potential side effects. (Questionnaires may be used)
- d) Maintain an up-to-date list of available donors of different groups.
- e) Donor safety and privacy

Survey process guide:

- GAHAR surveyor may review blood transfusion services policy during document review session.
- GAHAR surveyor may interview blood transfusion services healthcare professionals to check their awareness of the hospital policy.
- GAHAR surveyor may interview a person donating blood unit to inquire about assessment and counselling.
- GAHAR surveyor may review blood donation records.

- GAHAR surveyor may visit areas where blood donation occurs to check compliance with requirements.

Evidence of compliance:

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

Related standards:

DAS.25 Blood Transfusion services management

DAS.27 Processes of collection, handling, testing of blood, and blood components are performed according to national/international requirements.

Safety

Keywords:

Blood Procurement

Intent:

Blood collection has been practiced for centuries and is still an invasive procedure in healthcare. Each step in the process of blood collection, handling and testing affects the specimen quality, thus it is important for preventing specimen laboratory error, subsequent patient injury or even death. For example, the touch of a finger to verify the location of a vein before insertion of the needle increases the chance that a specimen will be contaminated. This can cause prolong hospitalization, delay diagnosis, and cause unnecessary use of antibiotics.

The hospital develops and implements 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

Survey process guide:

- GAHAR surveyor may review blood transfusion services policy during document review session.
- GAHAR surveyor may perform a tracer session on a person donating blood unit 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 on requirements for handling of blood units.
- GAHAR surveyor may visit areas where blood collection occurs to check compliance with requirements.

Evidence of compliance:

1. The hospital has an approved policy that describes all elements mentioned in the intent from a) through d) and based on national guidelines.
2. Blood bank staff are aware of the hospital's policy.
3. Blood and/or blood components are collected and handled as elements from a) through b) and based on national guidelines.
4. Blood and/or blood components are tested and prepared as elements from c) through d) and based on national guidelines.

Related standards:

DAS.26 Safe blood donation, DAS.25 Blood Transfusion services management

DAS.28 Blood and blood components are labelled, stored in the blood bank according to regulations and national requirements.

Effectiveness

Keywords:

Blood Storage

Intent:

Blood banking is logistic in nature. It attempts to bring the potentially life-saving benefits of transfusion to the patient who needs them by making blood and/or blood components available, safe, effective and cheap.

The easiest way to ensure the timely availability of blood and/or is to have an appropriate inventory on the shelf at all times.

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:

- a) Traceable number
- b) Name of blood bank
- c) Product type and volume
- d) Blood group and Rh group
- e) Seronegative
- f) Used anticoagulant, when applicable
- g) Required storage conditions.
- h) Date of collection
- i) Date of expiry

Storage conditions should limit deterioration and prevent damage to materials in process and final products. Storage should be access-controlled.

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.

Expiry dates should be monitored, recorded, and actions are taken for expired blood or blood components as per approved guidelines.

Blood bank should have physical separation between screened and unscreened blood bags Method of disposal of blood bags Should comply with requirements of waste management rules, regulations, and approved hospital process.

Survey process guide:

- GAHAR surveyor may observe at the blood storage and preparation areas to assess storage conditions and labelling.
- GAHAR surveyor may visit 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.
- GAHAR surveyor may review documentation and logs related to the tracking system to verify the traceability of blood and blood products from entry into the hospital to transfusion, discard, or transfer.

Evidence of compliance:

1. There is a system in place to ensure that blood/blood component bags are labelled seronegative according to serological investigation.
2. Labels of blood and/or blood components include all elements in the intent from a) through i).
3. There is a system in place to trace blood and blood products from entry into the hospital to transfusion, discard or transfer.
4. Blood and/or blood components are stored under access-controlled and recorded temperature-controlled conditions.
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.25 Blood Transfusion services management.

DAS.29 The hospital has a process to select and inspect outsourced blood and blood components.

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, hospital 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 hospital shall develop a policy and procedure for proper control of outside blood bank service, 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 laboratory.
- b) Evaluation:
The blood bank should implement an evaluation process before starting relationship by assessing blood bank accreditation status, inspection reports, performing an on-site 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).
- 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:

- ix. Checking for meeting predefined acceptance criteria for each blood component received.
- x. Evaluation and verification of units' identification information including unit numbers, ABO/Rh-D and Expiration dates.
- xi. Conformation of ABO/Rh-D for RBC components.
- xii. Actions taken for unsatisfactory blood or blood component units.
- xiii. Evaluation and verification of the transportation condition of each blood component.

Survey process guide:

- GAHAR surveyor may review hospital policy during document review session and review contracted blood bank agreement and results during financial stewardship session or leadership interview session.
- 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.
- GAHAR surveyor may review records in the blood bank or observe the receiving process to verify that inspection records support compliance.

Evidence of compliance:

1. The hospital 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 xiii).
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:

OGM.13 Contract Management, DAS.27 Blood Procurement, DAS.28 Blood Storage

DAS.30 The hospital has a process to ensure safe distribution of blood and/or blood components.

Safety

Keywords:

distribution of blood and blood components

Intent:

Distribution of blood and/or blood components is a big line of defence 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 hospital 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 be visually inspected before distribution. It should not be distributed if there is any evidence of leakage, haemolysis, or suspicion of microbial contamination such as unusual turbidity or change of colour.

Also, 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 be taken when required blood type is not available.

Survey process guide:

- GAHAR surveyor may review hospital blood distribution policy during the document review session.
- GAHAR surveyors may check blood sample labels and may review records of transfusion requests, and cross matching reports to ensure they meet all requirement.
- GAHAR surveyor may interview blood transfusion services staff members, nurses, porters and other healthcare professionals involved in blood unit issuance to inquire about the process and its variations.
- GAHAR surveyor may observe the process to check the compliance with the requirement.

Evidence of compliance:

1. The hospital has an approved policy that describes all elements mentioned in the intent from a) through h).
2. Blood bank staff members are aware of the hospital policy.
3. Blood sample label and blood transfusion request are completed with all required data and cross-checked before issuing blood or blood components.
4. Cross matching reports show recipient and donor data.
5. Standard compatibility test is completed promptly.
6. If discrepancy in the result is noted, the concerned healthcare professional is informed immediately to discontinue the transfusion.

Related standards:

DAS.25 Blood Transfusion services management, ACT.03 Patient identification.

Surgery, Anesthesia, and Sedation

Chapter intent:

Generally, surgery and invasive procedures refer to a technology consisting of a physical intervention on human tissues. This definition includes those procedures that investigate and/or treat diseases and disorders of the human body to:

- 1) Take out or eliminate all or a portion of a body part through excision, resection, extraction, destruction, or detachment.
- 2) Putting in or on, putting back, or moving living body parts through transplantation, reattachment, repositioning, or transfer.
- 3) Remove or eliminate solid matter, fluids, or gases from body parts.
- 4) Bypass, dilation, occlusion, or restriction of a tubular body part.
- 5) Insertion, replacement, supplementation, removal, change, or revision of a device attached to the body.
- 6) Cutting, revising, releasing, altering, creating, or fusing a body part.
- 7) Stopping or attempting to stop post-procedural bleeding.
- 8) Restoring a body part to its normal anatomic structure and function.
- 9) Cutting, removing, altering, or insertion of diagnostic/therapeutic scopes.

The scope of this chapter covers any surgical or invasive procedure performed in any of the following services/places:

- 1) Operation Rooms (OR), whether used for hospitalized patients, outpatients, or emergency patients.
- 2) Endoscopy unit.
- 3) Catheterization laboratory.
- 4) Emergency rooms.
- 5) Interventional radiology.
- 6) Outpatient rooms.
- 7) Any other unit in the hospital, either with or without anesthesia or sedation, including local anesthesia.

Surgical and invasive procedures include an approach to the human body that may be:

- 1) Through skin or mucous membrane, whether through an open cut or percutaneous or percutaneous endoscopic.
- 2) Through an orifice via an opening, endoscopic opening, or opening with percutaneous endoscopic assistance.

Procedural sedation is defined as the technique of administering sedatives or dissociative agents with or without analgesics to induce an altered state of consciousness that allows the patient to tolerate painful or unpleasant procedures while preserving cardiorespiratory function.

GAHAR surveyor shall survey all areas where surgery, invasive procedures, anesthesia, or sedation are taking place to ensure patient safety, staff competency, and effective utilization of these areas.

Chapter purpose:

1. Safe and effective surgical and invasive procedures care.
2. Safe and effective anesthesia care.
3. Safe and patient-centered sedation services.

SAS Chapter Summary of Changes

Summary of Changes Chapter 7

2025 Edition standard number	2021 Edition standard number	Changes description
SAS.01 KW: Surgery and Invasive Procedure Services	SAS.01 KW: Surgery and Invasive Procedure Services	<ol style="list-style-type: none"> 1- Rephrasing of Standard statement to be: (Provision of surgical and invasive procedure services follows applicable laws, regulations, and professional practice guidelines). 2- Added new EOC (EOC.04 There are professional practice guidelines in place to guide the proper provision of surgical and invasive procedures).
SAS.02 KW: Booking of surgeries and invasive procedures	SAS.02 KW: Booking of surgeries and invasive procedures	<ol style="list-style-type: none"> 1- Rephrasing of standard statement to be: (The hospital has a process in place for booking surgical and invasive procedures). 2- Rephrasing of (EOC.01 & EOC.05) in Hospital 2025. 3- Modified EOCs: (EOC.02: There is an ongoing process to ensure that booked procedures match the clinical privileges of the booking physicians). 4- Modified EOC: (EOC.04: There is a process for analyzing postponed and cancelled procedures and action is taken to improve them).
SAS.03 KW: Assessment before surgery and invasive procedures	SAS.03 KW: Assessment before surgery and invasive procedures	<ol style="list-style-type: none"> 1- Rephrasing of standard statement:(Comprehensive medical and nursing assessment is performed before surgical and invasive procedures). 2- Rephrasing of (EOC.01 & EOC.02).
SAS.04 KW: Brief assessments	SAS.04 KW: Brief assessments	<ol style="list-style-type: none"> 1- Rephrasing of standard statement: (In life-threatening emergencies, a brief medical assessment and planning are performed). 2- Modified EOC: (EOC.02: Anesthesia risk assessment of the patient's condition is determined before surgery).

2025 Edition standard number	2021 Edition standard number	Changes description
SAS.05. KW: Surgical Site Marking	SAS.05 KW: Surgical Site Marking	<p>1- Modified standard statement (The precise site where surgery or invasive procedure shall be performed is clearly marked by the physician, along with the patient and/or family involvement.).</p> <p>2- Modified EOC.02: (Involved staff are aware of the implementation of site marking).</p> <p>1. Modified EOC.01: (The hospital has an approved policy guiding the site marking process that includes at least elements from a) through g) mentioned in the intent).</p> <p>2. Modified EOC.04: (Site marking is performed before sending the patient to the operating room, involving the patient and the patient's family).</p> <p>3- Updated EOC: (EOC.05) by Merging two EOCs: (EOC.05 & EOC.06) in Hospital edition 2021.</p>
SAS.06 KW: Pre-Operative Checklist	SAS.06 KW: Pre-Operative Checklist	<p>1. Modified EOC.01: (The hospital has a process for preoperative verification of all needed documents and equipment).</p> <p>1- Added a new EOC: (EOC.02: The Staff involved are trained on the hospital process for preoperative verification).</p> <p>2- Modified EOC.03: (A recorded evidence of preoperative verification, of all items mentioned in the intent before each surgery or invasive procedure exists).</p> <p>2. Updated EOC: (EOC.04) by merging two EOCs: (EOC.03 & EOC.04) in Hospital edition 2021.</p>
SAS.07 KW: Time-out / sign-out	SAS.07 KW: Timeout	<p>1- Modification of standard statement to be: (Time-out is conducted before starting surgical and invasive procedure and sign-out is done before leaving the procedure location).</p> <p>2- Rephrasing of (EOC.01 – EOC.02).</p> <p>3- Added a new EOC.03: (Sign-out is conducted at the end of all surgical and invasive procedures and before leaving the operating location).</p>

2025 Edition standard number	2021 Edition standard number	Changes description
		1. Updated EOC: (EOC.04) by merging two EOCs: (EOC.04 & EOC.05) in Hospital edition 2021.
SAS.08 KW: Operative report	SAS.08 KW: Operative report	1- Modified standard statement to be (Surgical or invasive procedure details are recorded immediately after the procedure). 2- Modified EOC: (EOC.02: The report includes at least items from a) to i) in the intent).
SAS.09 KW: Instrument Retention Prevention	SAS.09 KW: Instrument Retention Prevention	1. Added a new EOCs: <ul style="list-style-type: none"> EOC.01 (The hospital has a process to manage surgical counts). EOC.04 There is a process to manage and deal with miscounts once identified). 2. Updated EOC (EOC.03) by merging two EOCs: (EOC.02 & EOC.03) in Hospital edition 2021. 3. Updated EOC (EOC.05) by merging two EOCs (EOC.04 & EOC.05) in Hospital edition 2021.
SAS.10 KW: Pathological Examination	SAS. 10 KW: Pathological Examination	1- Rephrasing of standard statement (Surgically removed tissue is sent for pathological examination unless present in the list of exempted tissues from the pathological examination). 2- Modified of (EOC.03 and EOC.04).
SAS. 11 KW: Implantable Device	SAS. 11 KW: Implantable Device	1- Rephrasing of standard statement (The hospital has a system for managing implantable devices including recall). 2- Added a new EOC: EOC.01 (The hospital has an approved policy for managing implantable devices that include items from a) through h) in the intent)

2025 Edition standard number	2021 Edition standard number	Changes description
SAS.12 KW: Post-operative care	SAS.12 KW: Post-operative care	1- Rephrasing of EOC1. 2- Added a new EOC: (EOC.02: Postoperative care plans are developed based on identified postoperative needs). 3- Modified EOC.04: (The postoperative care plan is implemented and updated based on changes in clinical conditions).
SAS.13 KW: Anaesthesia Services	SAS.13 KW: Anaesthesia Services SAS.14 KW: Qualified Anesthesiologist	1- Updated standard (SAS.13) by Merging two standards (SAS.13 & SAS.14) in Hospital edition 2021.
SAS. 14 KW: Uniform anaesthesia care	SAS. 15 KW: Uniform anaesthesia care	No change
SAS. 15 KW: Anaesthesia protocol	SAS. 16 KW: Anaesthesia protocol	No change
SAS. 16 KW: Anaesthesia plan	SAS. 17 KW: Anaesthesia plan	1- Modification of standard statement (A qualified anaesthesiologist performs pre-anaesthesia and pre-induction assessment and plans for anaesthesia care). 1. Modified EOC.02: (After performing the pre-anesthesia assessment, a detailed anesthesia plan is developed for each patient, including items from a) through f) in the intent). 2- Modified EOC.05: (Immediate pre-induction assessment is performed by the anaesthesiologist and recorded in the patient's medical record)
SAS. 17 KW: Physiological assessment by anaesthesia	SAS. 18 KW: Physiological assessment by anaesthesia	1. Modification of EOC.01 (The patient's physiologic status is monitored during anaesthesia based on hospital-approved professional practice guidelines). 1- Rephrasing of EOC.03 (The results of the monitoring are recorded in the patient's medical record regularly according to the approved professional practice guidelines/protocols).

2025 Edition standard number	2021 Edition standard number	Changes description
SAS. 18 KW: Patient care during anaesthesia	SAS. 19 KW: Patient care during anaesthesia	Rephrasing of standard statement (The hospital has an established process for patient care during anaesthesia).
SAS. 19 KW: anaesthesia Care Unit Equipment	SAS. 20 KW: Post anaesthesia Care Unit Equipment	<ol style="list-style-type: none"> 1- Rephrasing of standard statement (post-anaesthesia care unit is equipped according to applicable laws, regulations, and professional practice guidelines). 2- Rephrasing of (EOC.02). 3- Modified EOC.03 (All needed supplies and medications are identified, available and checked properly).
SAS. 20 KW: anaesthesia Post care Monitoring	SAS. 21 KW: Post anaesthesia care Monitoring	<ol style="list-style-type: none"> 1- Modification of standard statement (Patient's monitoring in post-anaesthesia care unit and the decision of the discharge/transfer from the unit are performed according to laws and regulations and professional practice guidelines). 2- Rephrasing of EOC.01. 3- Updated EOC: (EOC.02) by merging two EOCs (EOC.02 & EOC.03) in Hospital edition 2021. 4- Added a new EOC.03: (There is a process in place to manage the monitoring of cases transferred directly from the OR to critical care units).
SAS. 21 KW: Sedation protocol	SAS. 22 KW: Sedation protocol	<ol style="list-style-type: none"> 1- Rephrasing of standard statement (Procedural sedation techniques and management of related complications are guided by clinical protocols). 2- Added new EOCS: <ul style="list-style-type: none"> • EOC.02: (There is an approved policy guiding the management of procedural sedation that covers from a) to e) in the intent). • EOC.03: (The involved staff are aware about the policy requirements for procedural sedation).

2025 Edition standard number	2021 Edition standard number	Changes description
		<ul style="list-style-type: none"> EOC.05: (The staff's competency in performing and monitoring procedural sedation is ensured).
SAS. 22 KW: Sedation plan	SAS. 23 KW: Sedation plan	1- Rephrasing of standard statement (pre-procedural sedation assessment and procedural sedation plan are performed by competent physicians).
SAS. 23 KW: Procedural sedation physiological status monitoring, Care during procedural sedation	SAS. 24 KW: Sedation physiological status monitoring SAS. 25 KW: Care during Sedation	1- Updated standard (SAS.23) by merging two standards (SAS.24 & SAS.25) in Hospital 2021.
SAS.24 KW: Post-procedural sedation care, Post sedation monitoring	SAS. 26 KW: Post-procedural sedation care. SAS.27 KW: Post sedation monitoring	1- Updated standard (SAS.24), by merging two standards (SAS.26 & SAS.27) in Hospital edition 2021.

Safe and effective surgical and invasive procedures care

SAS.01 Provision of surgical and invasive procedure services follows applicable laws, regulations, and professional practice guidelines.

Safety

Keywords:

Surgery and Invasive Procedure Services

Intent:

The laws, regulations, and professional practice guidelines control the provision of surgery and invasive procedure services by determining the appropriate spaces, infrastructure, patient flow, clean and waste flow, and minimum required equipment and staffing.

The hospital is required to provide surgery and invasive procedure services all over the hospital safely by providing the required resources as obliged by national laws and regulations.

Survey process guide:

- GAHAR surveyor may observe the place, infrastructure supplies, medications, and equipment available by visiting the operating room department, endoscopy unit, cardiac catheterization unit, and any special unit where surgery or invasive procedures are performed.
- GAHAR surveyor may interview staff members to ask about patient flow and clean and waste flow.
- GAHAR surveyor may review the corresponding staff files for those who performed surgeries and invasive procedures to check their qualifications and competencies.

Evidence of compliance:

1. All units providing surgery and invasive procedure services have appropriate spacing, ventilation, and infrastructure, including medical gases, and are well maintained.
2. All units providing surgical and invasive procedure services have appropriate equipment, medical supplies, and medication.
3. All surgical and invasive procedure staff are qualified and competent.
4. There are professional practice guidelines in place to guide the proper provision of surgical and invasive procedures.

Related standards:

EFS.01 Hospital environment and facility safety management, WFM.12 Clinical Privileges, IMT. 08 Patient's Medical record Management, ICD.04 Emergency Care Guidelines.

SAS.02 The hospital has a process in place for booking surgical and invasive procedures.

Safety

Keywords:

Booking of surgeries and invasive procedures

Intent:

The process of booking the elective procedures is a critical step in running the operating rooms and all other units where surgeries and invasive procedures are performed.

Applying proper booking, while taking into consideration the allowed elective time, staffing level, and clinical privileges of physicians, should be taken into consideration to ensure effective utilization of the unit as well as patient safety.

The hospital shall develop and implement a policy and procedures for booking surgical and invasive procedures that address at least the following:

- a) Surgeries and invasive procedures are booked according to granted clinical privileges.
- b) The booking should specify the start time and end time for surgery based on the international surgery times.
- c) The hospital records surgeries and invasive procedures, whether they are scheduled, performed, or canceled.
- d) Clear and safe mechanism to identify patients in the records.
- e) A clear and safe mechanism to call patients for surgeries or invasive procedures.

Analysis of the postponed and canceled surgeries and invasive procedures supports the hospital with reliable data for better management and utilization of the available resources.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the booking process for surgeries and invasive procedures, followed by interviewing involved staff members to check their awareness.
- GAHAR surveyor may review the recorded documents of the booking process to ensure ongoing accuracy and consistency of the process and analyze the causes of postponing and/or canceling surgeries or invasive procedures.
- GAHAR surveyor may review the related documents to check the recorded timing of all patient flow steps inside the unit and analyze this punctuality.
- GAHAR surveyor may review staff files of physicians requesting booking or performing surgical and invasive procedures to ensure that their clinical privileges are appropriate to/matched with those types of surgeries and invasive procedures.

Evidence of compliance:

1. The hospital has an approved policy and procedures guiding the booking process that addresses all elements mentioned in the intent from a) through e).
2. There is an ongoing process to ensure that booked procedures match the clinical privileges of the booking physicians.
3. There is an ongoing process for booking all elective procedures and determining the needed time for each procedure.
4. There is a process for analyzing postponed and canceled procedures, and action is taken to improve them.
5. Punctuality (timekeeping) of procedures in the operating room is maintained and recorded, starting with the patient's call and ending with the room being cleaned after the procedure.

Related standards:

WFM.12 Clinical Privileges, QPI.06 Clinical Performance Measures, ICD.15 Plan of care.

SAS.03 Comprehensive medical and nursing assessment is performed before surgical and invasive procedures.

Safety

Keywords:

Assessment before surgery and invasive procedures

Intent:

Completed patient assessment before surgery by requesting the needed investigations to ensure the diagnosis, reveal risk factors, assess patient medical condition, or determine baseline patient condition, followed by proper management of all identified diagnoses and risk factors.

Accordingly, risk assessment of the patient's condition is needed for all surgeries to determine the necessary precautions and inform 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 hospital must perform a complete patient assessment before any elective surgery, supported by the results of the required investigations, followed by a risk evaluation for the surgery.

Survey process guide:

- GAHAR surveyor may review a sample of medical records of patients who underwent surgery or invasive procedure to ensure compliance with a complete assessment of the patient, availability of results of requested investigations, risk classification before surgery or invasive procedure, informed consent, and appropriate management of the risk factors.
- GAHAR surveyor may interview involved medical and nursing staff members to check their awareness.

Evidence of compliance:

1. A complete preoperative medical assessment is performed for all patients undergoing surgery or invasive procedure.
2. A complete preoperative nursing assessment is performed for all patients undergoing surgery or invasive procedure.
3. Results of investigations are available for healthcare professionals before the surgery or invasive procedure.
4. The identified risks of the patient's conditions are documented in the patient's medical record before surgery or invasive procedure.
5. Action is taken to manage the risk factors before the surgery or invasive procedure.

Related standards:

ICD.15 Plan of care, MT. 08 Patient's Medical record Management, SAS.02 Booking of surgeries and invasive procedures, WFM.15 Nursing laws and regulations, WFM.05 Verifying credentials, SAS.16 Anesthesia Plan.

SAS.04 In life-threatening emergencies, a brief medical assessment and planning are performed.

Timeliness

Keywords:

Brief assessments

Intent:

Life-threatening emergencies require immediate intervention to save the patient's life. In such situations, a complete patient assessment could be time-consuming and compromise the patient's condition.

The hospital is required to perform a focused patient assessment, which should be documented in the patient's medical record for the medicolegal issues and proper communication between staff, followed by determining the patient's plan of care and immediate intervention. The focused patient assessment shall include at least the following:

- a) Patient needs and condition.
- b) Preoperative diagnosis.
- c) Plan for surgery / invasive procedure.

Survey process guide:

- GAHAR surveyor may review a sample of patients' medical records for those who underwent emergency surgery to check the focused patient's assessment related to the patient's medical condition.

- GAHAR surveyor may review a sample of patients' medical records for those who underwent emergency surgery to ensure an anesthesia risk assessment is determined before surgery and risk classification is completed by the time of intervention.
- GAHAR surveyor may interview involved staff members to ensure their awareness.

Evidence of compliance:

1. A focused medical assessment is performed for patients undergoing life-threatening surgery.
2. Anesthesia risk assessment of the patient's condition is determined before surgery.
3. The focused assessment is documented in the patient's medical record.
4. The plan of care is performed on time for those patients.

Related standards:

ICD.04 Emergency Care Guidelines, SAS.16 Anesthesia Plan, WFM.12 Clinical Privileges, IMT. 08 Patient's Medical record Management,

SAS.05 GSR.14 The precise site where surgery or invasive procedure shall be performed is clearly marked by the physician, along with the patient and/or family involvement.

Safety

Keywords:

Surgical Site Marking

Intent:

Performing the right surgery on the right patient and the right side without any retained instrument is the main objective of surgical safety. Surgical Site Marking is an error reduction strategy. Establishing related policies and procedures, known as the universal protocol, is the initial step for offering safe surgery. The hospital shall develop and implement a policy and procedures for the site marking process that includes at least the following:

- a) Unified mark on the nearest surgical site.
- b) Indication of site marking.
- c) The physician who will perform the surgery / invasive procedure is responsible for site marking.
- d) Involvement of the patient.
- e) Surgeries and procedures exempted from site marking.
- f) Appropriate time for surgical site marking before surgery.
- g) Monitoring compliance with the process.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the site marking process.
- GAHAR surveyor may interview involved staff members to check their awareness of the hospital policy.
- GAHAR surveyor may observe to check the presence of a clear, approved, non-washable mark on the surgery / invasive procedure site (when applicable)

Evidence of compliance:

1. The hospital has an approved policy guiding the site marking process that includes at least elements from a) through g) mentioned in the intent.
2. Involved staff are aware of the implementation of site marking.
3. Site marking is a unified mark throughout the hospital and is performed by the physician responsible for the surgery or invasive procedure.
4. Site marking is performed before sending the patient to the operating room, involving the patient and the patient's family.

5. The hospital monitors the reported data regarding the site marking process and takes actions to control or improve the process as appropriate.

Related standards:

ACT.03 Patient identification, SAS.07 Time-out/sign-out, WFM.12 Clinical Privileges, PCC.07 Patient and family education process, SAS.03 Assessment before surgery and invasive procedures.

SAS.06 GSR.15 Documents and equipment needed for procedures, anesthesia, or sedation are verified to be on hand, correct, and properly functioning before calling for the patient.

Safety

Keywords:

Pre-Operative Checklist

Intent:

Ensuring the availability of all needed items, such as blood booking, the results of the requested investigation, or a special prosthesis, should be done as a preoperative 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 the cancellation of surgery and invasive procedures after the patient goes to the operating rooms or invasive procedure unit. Implementing regular checkups is a quality improvement process that should be guided by designed checklists and performed by trained staff.

The hospital 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 differ according to the type of surgery and invasive procedure or the use of anesthesia and sedation.

Also, the hospital is required to have a process for preoperative verification of the availability of all needed or requested documents and other items before the patient goes for surgery or an invasive procedure. The preoperative verification process shall include the following:

- The identification of the patient and the planned procedure with the involvement of the patient/family.
- The availability and functioning of needed equipment.
- Informed consent and related education to the patient
- Precise site marking
- Results of requested investigations and diagnostic imaging
- Blood booking and ensuring blood availability.
- Implantable devices and special prostheses.
- Special precautions for infection control preparation.

Survey process guide:

- GAHAR surveyor may interview involved staff to check their awareness of the hospital preoperative verification process, followed by tracing the patient who underwent or is going to undergo surgery / invasive procedure to ensure the correct verification process for needed documents and other requested orders, such as blood booking or investigations.
- GAHAR surveyor may observe patient endorsement to the operating room or other invasive procedure unit.
- GAHAR surveyor may review the document of endorsement and the checklist showing the availability and functioning of needed equipment.

Evidence of compliance:

1. The hospital has a process for preoperative verification of all needed documents and equipment.

2. The staff involved are trained on the hospital process for preoperative verification.
3. Recorded evidence of preoperative verification of all items mentioned in the intent before each surgery or invasive procedure exists.
4. The hospital monitors the reported data on the preoperative verification process and takes actions to control or improve the process as appropriate.

Related standards:

ACT.03 Patient identification, SAS.01 Surgery and Invasive Procedure Services, PCC.08 Informed consent, SAS.05 Surgical Site Marking.

SAS.07 GSR.16 Time-out is conducted before starting surgical and invasive procedures, and sign-out is done before leaving the procedure location.

Safety

Keywords:

Time-out/sign-out

Intent:

Time out for verification of the correct patient, correct surgery or invasive procedure, and correct site and side of surgery or invasive procedure is a single process proven to reduce wrong-site surgery. The surgery or invasive procedure team, including the performing physician, the nurse, and the anesthesiologist, when applicable, is involved in the time-out process.

When performing a surgery or invasive procedure, healthcare professionals should verify the right patient, the right type of surgery, the right site, the right side, and the patient receiving prophylactic antibiotics if applicable.

The team shall not start the surgical or invasive procedure before resolving any conflict or confusion the team members could raise.

The hospital shall develop and implement a policy and procedures to ensure the correct patient, the correct surgery or invasive procedure, and the correct site and side of the surgery or invasive procedure. The time-out process shall be applied just before the start of the surgery or invasive procedure (after induction of anesthesia).

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 hospital policy guiding the time-out process and interview involved staff members to ensure their awareness.
- GAHAR surveyor may observe a case during the time-out process and ensure process conduction before starting surgical or invasive procedure (if applicable).
- GAHAR surveyor may review a sample of patients' medical records for those who underwent surgery/invasive procedure and related documents to check time-out process/sign-out process documentation.

Evidence of compliance:

1. The hospital has an approved policy to ensure the correct patient, procedure, and body part before surgical or invasive procedures.
2. Time out is done immediately before surgery or invasive procedure starts.
3. Sign-out is conducted at the end of all surgical and invasive procedures and before leaving the operating location.

4. The hospital monitors the reported data on time-out and sign-out processes and takes actions to control or improve the process as appropriate.

Related standards:

SAS.06 Pre-Operative Checklist, SAS.05 Surgical Site Marking, WFM.12 Clinical Privileges, ACT.03 Patient identification, IMT. 08 Patient's Medical record Management.

SAS.08 Surgical or invasive procedure details are recorded 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 hospital is requested to immediately report the procedure details before the patient leaves the procedural unit. Recording the names of all staff involved in the procedure has a medicolegal 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 of the procedure is done. The use of any prosthesis or implantable devices should be stated in the report, including any special precautions when dealing with or removing it.

Complications that occur during the procedure should be recorded, along with the actions taken to manage them. Any specimen removed from the body should also be stated clearly in the procedure report.

The report should address 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 and findings.
- e) The details of any implantable device or prosthesis used, 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 a sample of patients' medical records for those who underwent surgeries/invasive procedures to check the completeness of all components needed in the procedure report.

Evidence of compliance:

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

Related standards:

IMT. 08 Patient's Medical record Management, SAS.16 Anesthesia Plan, SAS.13 Anesthesia Services, SAS.01 Surgery and Invasive Procedure Services, ACT.08 Handover communication

SAS.09 GSR.17 The accuracy of counting sponges, needles, and instruments pre- and post-procedure is verified.

Safety

Keywords:

Instrument Retention Prevention

Intent:

Missing sponges, suture reels, needles, blades, towels, or instruments inside the patient's body act as a foreign body and cause serious morbidity in the form of pain, organ injury and sepsis, which necessitate reopening the patient and could reach up to mortality.

The surgical team should spend all efforts to prevent missing any foreign body during surgery/invasive procedure by meticulously counting any item used 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 hospital process guiding accurate counting of sponges, needles, and instruments pre- and post-procedure, followed by interviewing involved staff members to check their awareness, and may inquire about the actions to be taken in case of an identified miscount.
- GAHAR surveyor may observe a case during or after surgery or an invasive procedure (if applicable).

Evidence of compliance:

1. The hospital has a process to manage surgical counts.
2. Two staff members count sponges, needles, towels, or instruments before, during, and after the surgery or invasive procedure, as the second one acts as a witness for the first one.
3. The preoperative, intraoperative, and postoperative counts are recorded, and the performing physician signs the record.
4. There is a process to manage and deal with miscounts once identified.
5. The hospital monitors the reported data on the counting process and takes actions to control or improve the process as appropriate.

Related standards:

QPI.10 Incident Reporting System, SAS.07 Time-out/sign-out, SAS.08 Operative Report, SAS.01 Surgery and Invasive Procedure Services,

SAS.10 Surgically removed tissue is sent for pathological examination unless present in the list of exempted tissues from the pathological examination.

Effectiveness

Keywords:

Pathological Examination

Intent:

Surgically removed tissue from the human body needs to 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 may also depend on findings in the examination of the frozen section. Some surgically removed tissues do not need to be pathologically examined. The hospital should clearly identify these tissues as exempt from pathological examination in routine cases unless requested by the physician.

Surgically removed tissues are labeled with the date and time, patient identification, and tissue type. The hospital is required to design a pathway for tissues removed from the human body to obtain a sample for laboratory examination, which is then sent to the appropriate disposition according to the type of tissue.

Survey process guide:

- GAHAR surveyor may review a sample of patients' medical records for those patients who underwent surgical removal of tissues/body parts and sent for pathological examination to check the availability of pathology results and the time frame of the results.
- GAHAR surveyor may interview involved staff members in the operating room and pathology laboratory to check their awareness.
- GAHAR surveyor may review related documents in the operating room and pathology laboratory.
- GAHAR surveyor may observe the pathway of a surgically removed tissue/body part till its disposition and labeling of surgically removed tissues with date, patient identification, and tissue type (if applicable).

Evidence of compliance:

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

Related standards:

SAS.03 Assessment before surgery and invasive procedures, WFM.12 Clinical Privileges, ACT.03 Patient identification, SAS.08 Operative Report.

SAS.11 The hospital has a system for managing implantable devices, including recall.

Safety

Keywords:

Implantable Devices

Intent:

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

Examples include orthopedic prostheses, stents, intracardiac defibrillators, cardiac pacemakers, intraocular lenses, intrauterine devices, and dental implants.

Using implantable devices involves many considerations, including special instructions for use, sterility, manufactural considerations, and malfunction.

The hospital is required to track the implantable device from its primary source to discover any unstable, contaminated, defective, or imitated product.

Every patient with an implantable device should be easily identified and reachable within a defined time frame to be ready for any device recall.

The hospital shall develop and implement a policy to manage the implantable devices that include:

- a) The selection process of implantable devices.
- b) Process for procurement and availability in the operating location.
- c) Technical staff qualification and competency from internal or external (company representative).
- d) Recording and documenting of implantable device in the patient's and OR records.
- e) Process and criteria of identifying and reporting adverse events related to implantable device.
- f) Tracking and recall of devices.
- g) Process of reporting malfunctions of implantable devices to authorities.
- h) Discharge instructions, including infection prevention requirements.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding implantable devices management and the list of implantable devices used in the hospital.
- GAHAR surveyor may observe the process to ensure the presence of a process for retrospective tracing of any implantable device.
- GAHAR surveyor may review a sample of patient's medical records who underwent device implantation, to check procedure report details including the batch number.

Evidence of compliance:

1. The hospital has an approved policy for managing implantable devices that include items from a) through h) in the intent.
2. There is a list of implantable devices used in the hospital.
3. There is a process for retrospective tracing of any implantable device.
4. The procedure report includes the details of any used implantable device, including the batch number.
5. There is a process for the recall of a patient who has an implantable device when necessary.

Related standards:

SAS.06 Pre-Operative Checklist, SAS.08 Operative Report, OGM.10 supply chain management, QPI.10 Incident Reporting System.

SAS.12 Postoperative care plan is determined and recorded before patient transfer.

Patient-centeredness

Keywords:

Post-operative care

Intent:

Postoperative care is a leading factor in determining procedure outcomes.

Creating the postoperative care plan should start immediately after the procedure before the patient leaves the procedural room to prevent any delay, wrong, unnecessary, or missing care.

A postoperative plan of care is developed by the physician who performed the procedure and the anesthesiologist (when applicable) and includes the level of care, patient position, activity, required monitoring, diet, medications, intravenous fluids, and required investigations follow-up.

Survey process guide:

- GAHAR surveyor may review a sample of patient's medical records who underwent surgical procedures to ensure the procedure-performing physician develops the postoperative plan of care.
- GAHAR surveyor may observe postoperative plan of care implementation, including related physician orders.

Evidence of compliance:

1. There is a postoperative care plan for all patients performed the procedure developed by the performing physician.
2. Postoperative care plans are developed based on identified postoperative needs.
3. The postoperative care plan is documented in the patient's record before leaving the procedure room.
4. The postoperative care plan is implemented and updated based on changes in clinical conditions.

Related standards:

ICD.15 Plan of care, ACT.08 Handover communication, SAS.08 Operative Report.

Safe and effective anesthesia care

SAS.13. Anesthesia and sedation services are provided in accordance with applicable laws, regulations, and professional practice guidelines under the supervision of a qualified anesthesiologist.

Safety

Keywords:

Anesthesia Services

Intent:

The provision of anesthesia and sedation is a high-risk and problem-prone service. Laws, regulations, and professional practice guidelines set governing frameworks and controls for these services. Anesthesia services are performed by a qualified anesthesia physician with uniform provision of service throughout the hospital.

Sedation service could be performed by a physician if he/she is trained in performing sedation service and has a valid certificate in basic life support, provided that advanced life support is reachable within 5 minutes maximum under the overall responsibility of an anesthesiologist.

A minimum setup, including equipment, medications, medical supplies, and medical gases, shall be available for the safe performance of anesthesia and sedation.

The hospital is required to appoint a competently qualified anesthesiologist to lead the anesthesia and sedation services with a specific, detailed, and implemented job description.

The anesthesia leader determines the minimum requirements for providing service, including staffing, equipment, medications, and medical supplies.

Survey process guide:

- GAHAR surveyor may observe the provision of anesthesia and sedation services, the structure of the place, available equipment, medications, and medical supplies while visiting the hospital units where anesthesia and sedation are performed.
- GAHAR surveyor may review a sample of staff files to check the credentials of the staff involved in these services.
- GAHAR surveyor may review the anesthesia leader's staff file to ensure that the job description clearly outlines responsibilities.

- GAHAR surveyor may interview the anesthesia leader to inquire about the structure, process, and outcome of the anesthesia and sedation care.

Evidence of compliance:

1. The provision of anesthesia and sedation services meets the applicable professional practice guidelines, national laws, and regulations.
2. Minimum setups are available, which include equipment, medications, medical supplies, and medical gases.
3. All staff performing anesthesia and sedation services are qualified, competent, and appropriate in number.
4. There is a qualified leader for the anesthesia and sedation services with clear responsibilities.
5. The anesthesia and sedation leader evaluates the outcome of provided services and takes action based on the findings.

Related standards:

WFM.12 Clinical Privileges, EFS.01 Hospital environment and facility safety management, WFM.09 Staff Performance Evaluation,

SAS.14 Anesthesia and sedation services are uniform throughout the hospital and readily available 24 hours a day, seven days a week.

Safety

Keywords:

Uniform anesthesia care

Intent:

A shortage of qualified staff or proper equipment might lead to non-uniformity of anesthesia services, which could affect patient safety.

Safe provision of anesthesia and sedation services is required to be uniform all over the hospital and during the 24 hours without any changes in the structure or process used.

According to the hospital's scope and occupancy, an anesthesiologist (s) shall be present 24 hours a day, seven days a week, to support elective and emergency anesthesia services.

Survey process guide:

- GAHAR surveyor may review the schedule of anesthesiologists.
- GAHAR surveyor may interview the anesthesia team to ask about the distribution of duties and the daily tasks performed by them.

Evidence of compliance:

1. The provision of anesthesia services is uniform all over the hospital.
2. The provision of sedation services is uniform all over the hospital.
3. anesthesia and sedation services are readily available 24 hours, seven days a week, to meet elective and emergency patient needs.

Related standards:

SAS.13 Anesthesia Services, EFS.01 Hospital environment and facility safety management, EFS.10 Medical equipment plan, WFM.02 Staffing Plan, SAS.19 Anesthesia Care Unit Equipment.

SAS.15 Anesthesia techniques and management of serious anesthesia emergencies or complications are guided by clinical protocols.

Safety

Keywords:

Anesthesia Protocols

Intent:

Anesthesia emergencies or complications include but are not limited to vomiting, laryngospasm, difficult ventilation, and malignant hyperthermia. Management of anesthesia emergencies and complications is the most critical part of providing anesthesia care.

Written protocols for the management of complications ensure the professional management of these conditions if they occur. To unify the provision of anesthesia services, clinical protocols shall be developed for the approved anesthesia techniques based on professional practice guidelines. These protocols are designed according to the hospital's scope of service and the type of surgeries and invasive procedures. All anesthesia staff should be trained on and follow clinical protocols.

Anesthesiologists shall be ready all the time for any anesthesia emergencies or complications to deal with. This will occur through proper patient assessment, making sure of the availability of appropriate tools that will be used in the management of these conditions.

Survey process guide:

- GAHAR surveyor may review the anesthesia protocols and anesthesia emergencies and complications management protocols.
- GAHAR surveyor may interview the anesthesiologist to ask about the anesthesia protocols implementation.
- GAHAR surveyor may observe to check the availability of all equipment, medications, and medical supplies needed for the implementation of anesthesia emergencies and complications management protocols.

Evidence of compliance:

1. Hospital-approved protocols are implemented for anesthesia techniques used in the hospital.
2. Hospital-approved protocols are implemented for the management of anesthesia emergencies and complications.
3. The equipment, medications, and medical supplies needed during anesthesia emergencies and complications are readily available in the hospital.

Related standards:

SAS.13 Anesthesia Services, WFM.12 Clinical Privileges, EFS.10 Medical equipment plan, MMS.03 Medication Procurement, Formulary, SAS.17 Physiological assessment by anesthesia, SAS.19 Anesthesia Care Unit Equipment

SAS.16 A qualified anesthesiologist performs pre-anesthesia and pre-induction assessment and plans for anesthesia care.

Safety

Keywords:

Anesthesia Plan

Intent:

Anesthesia services usually start with a pre-anesthesia assessment. Pre-anesthesia assessment determines the patient's condition, risk scoring for receiving anesthesia, and required interventions/care before, during, and after receiving anesthesia.

The hospital is required to perform a pre-anesthesia assessment and pre-induction of anesthesia assessment for all patients before transfer to perform the surgeries by a qualified anesthesiologist. Assessment outcome includes risk scoring of receiving anesthesia, additional required investigations, other required specialty consultation, and premedication.

The anesthesiologist is required to record an anesthesia plan that includes:

- a) Type of anesthesia used, either local anesthesia, regional anesthesia, or general anesthesia.
- b) Technique of induction, including the used medications with doses, route, and time of administration.
- c) Airway management and patient ventilation.
- d) Fluid management, including deficit replacement and maintenance requirements, with a final estimation of the fluid balance, including the types of IV fluids, blood, or blood products used.
- e) Any medications or IV fluids administered during the anesthesia should also be timed.
- f) Any unusual event that occurred during anesthesia with the management that occurred for effective communication.

Survey process guide:

- GAHAR surveyor may trace a patient who received anesthesia to evaluate the process of pre-anesthesia assessment, including its validity and the process of development of an anesthesia plan of care.
- GAHAR surveyor may review a sample of patients' medical records for those who received anesthesia to check the pre-anesthesia assessment, including the risk scoring of receiving anesthesia and the anesthesia plan.
- GAHAR surveyor may review a sample of corresponding staff files to ensure that pre-anesthesia assessment and the anesthesia plan development are performed by a qualified anesthesiologist.

Evidence of compliance:

1. A pre-anesthesia assessment is performed for all patients before they receive anesthesia.
2. After performing the pre-anesthesia assessment, a detailed anesthesia plan is developed for each patient, including items from a) through f) in the intent.
3. Pre-anesthesia assessment and the anesthesia plan development is performed by a qualified anesthesiologist.
4. The pre-anesthesia assessment and the anesthesia plan are recorded in the patient's medical record.
5. Immediate pre-induction assessment is performed by the anesthesiologist and recorded in the patient's medical record.

Related standards:

SAS.03 Assessment before surgery and invasive procedures, SAS.13 Anesthesia Services, SAS.17 Physiological assessment by anesthesia, SAS.14 Uniform anesthesia care, IMT. 08 Patient's Medical record Management, SAS.15 Anesthesia Protocols.

SAS.17 A competent anesthesiologist performs continuous monitoring of the patient's physiological status before and during anesthesia.

Safety

Keywords:

Physiological assessment by anesthesia

Intent:

Administering anesthesia and performing surgeries and invasive procedures are associated with changes in the patient's physiologic status that could be very rapid. Accordingly, the patient's physiologic status is required to be continuously monitored starting from receiving the anesthesia to determine the baseline of the patient's condition, which is used in determining the patient's criteria for discharge from the post-anesthesia care unit.

The type of monitoring is determined according to the patient's condition, age, type of anesthesia, type, and duration of surgery based on the clinical practice guidelines.

Continuous monitoring allows the anesthesiologist to on-time intervention for any changes in the patient's condition.

Survey process guide:

- GAHAR surveyor may observe a patient while receiving anesthesia to evaluate the patient monitoring process and the staff involved in it.
- GAHAR surveyor may review a sample of patients' medical records for those who received anesthesia to ensure that the results of the patient monitoring during anesthesia are recorded in the patient's medical record regularly according to the approved professional practice guidelines/protocols.

Evidence of compliance:

1. The patient's physiologic status is monitored during anesthesia based on hospital-approved professional practice guidelines.
2. The monitoring of patient physiologic status is performed by a qualified anesthesiologist.
3. The results of the monitoring are recorded in the patient's medical record regularly according to the approved professional practice guidelines/protocols.

Related standards:

SAS.03 Assessment before surgery and invasive procedures, SAS.16 Anesthesia Plan, IMT. 08 Patient's Medical record Management, SAS.08 Operative Report.

SAS.18 The hospital has an established process for patient care during anesthesia.

Safety

Keywords:

Patient care during anesthesia

Intent:

To perform safe anesthesia, the process of anesthesia care does not include only the administration of anesthesia medications; it includes multiple acts, from induction of anesthesia (takeoff) to return the patient to the previous condition before anesthesia (landing).

As mentioned before, the patient's physiological status shall be continuously monitored and recorded before and during the administration of anesthesia. Finally, after the patient returns to the pre-anesthesia status, the physiological status shall be recorded.

The anesthesiologist shall order for patient transfer to either the post-anesthesia care unit or intensive care unit and record the time of transfer.

The anesthesia record includes at least the following:

- a) The patient's physiologic status.
- b) Time of anesthesia induction.
- 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's condition before leaving the theatre.
- i) Patient disposition.
- j) Time of transfer.
- k) Signature of the anesthesiologist

Survey process guide:

- GAHAR surveyor may observe and evaluate the process of anesthesia care.
- GAHAR surveyor may review a sample of patients' medical records to check the documented anesthesia care.

Evidence of compliance:

1. Anesthesia care is performed safely based on approved anesthesia techniques.
2. The implemented anesthesia care is recorded in the patient's medical record, including all elements from a) to k) in the intent.
3. A copy of the anesthesia record is kept in the patient's medical record.

Related standards:

SAS.15 Anesthesia Protocols, IMT. 08 Patient's Medical record Management, SAS.13 Anesthesia Services.

SAS.19 post-anesthesia care unit is equipped according to applicable laws, regulations, and professional practice guidelines.

Patient-centeredness

Keywords:

Anesthesia Care Unit Equipment

Intent:

Anesthesia risks may occur even in the post-anesthesia period, where the patient should be regularly monitored.

There should be a post-anesthesia care unit with at least one bed for each operating room.

The post-anesthesia care unit must be equipped with monitoring equipment, a crash cart with a defibrillator, an oxygen source, recommended medications, and medical supplies.

The post-anesthesia care unit shall be provided with all critical supplies and medications which are used to save patients' lives during emergencies. The recovery period is a critical period postoperatively for most cases.

Survey process guide:

- GAHAR surveyor may observe the units where anesthesia is performed in the hospital to check the area used for post-anesthesia care and ensure the availability of the equipment, supplies, and medications needed there.

Evidence of compliance:

1. There is a post-anesthesia care unit for each department where surgery or invasive procedures are performed.
2. The post-anesthesia care unit is equipped with the required equipment according to laws, regulations, and professional practice guidelines.
3. All needed supplies and medications are identified, available, and checked properly.

Related standards:

EFS.10 Medical equipment plan, MMS.03 Medication Procurement, Formulary, SAS.18 Patient care during anesthesia, MMS.05 Emergency medications, EFS.01 Hospital environment and facility safety management.

SAS.20 Patient monitoring in the post-anesthesia care unit and the decision of the discharge/transfer from the unit are performed according to professional practice guidelines.

Safety

Keywords:

Post-anesthesia care monitoring

Intent:

Post-anesthesia care includes monitoring the patient's physiological status, allowing anesthesiologists to intervene on time for any changes in the patient's condition, and determining the patient's criteria for discharge from the post-anesthesia care unit.

The type of monitoring is determined according to the professional practice guidelines based on the patient's condition, age, anesthesia used, type, and duration of surgery.

In some hemodynamically unstable patients, the surgeon with an anesthesiologist may decide to transfer the patient directly from the operating room to the critical care unit without passing through the post-anesthesia care unit to ensure the patient's safety. In such a situation, the first two hours in the receiving unit will be considered recovery time, which requires the frequency of monitoring and records similar to those used in the post-anesthesia care unit to ensure uniformity of care.

Patient monitoring is required to be done by a competent clinical practitioner.

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

The hospital is required to ensure good communication between staff in different units by ensuring the recording of exceptional or unusual events that occurred inside the post-anesthesia care unit with the management provided, the time of receiving the patient, and the time of transfer from the post-anesthesia unit. Competent clinical practitioner record includes at least the following:

- a) The patient's physiologic status.
- b) The time of receiving the patient.
- c) The 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's condition before leaving according to defined criteria.
- i) Patient disposition.
- j) Time of transfer from the post-anesthesia care unit.
- k) Signature of the clinical practitioner.

Survey process guide:

- GAHAR surveyor may trace a patient who received anesthesia till the post-anesthesia stage.
- GAHAR surveyor may observe the process to check monitoring cases transferred directly from the OR to critical care units.

- GAHAR surveyor may review a sample of patients' medical records for those who received anesthesia to check the recorded post-anesthesia care.

Evidence of compliance:

1. A competent healthcare practitioner performs post-anesthesia care.
2. The patient's physiologic status is monitored during post-anesthesia care, according to professional practice guidelines, and recorded in the patient's medical record.
3. There is a process in place to manage the monitoring of cases transferred directly from the OR to critical care units.
4. The provided post-anesthesia care from a) to k) in the intent is recorded in the patient's medical record.
5. A qualified anesthesiologist decides whether to transfer/discharge a patient from the postanesthetic care unit or by other practitioners according to defined criteria.

Related standards:

ICD.15 Plan of care, ACT.08 Handover communication, SAS.15 Anesthesia Protocols, WFM.09 Staff Performance Evaluation, WFM.12 Clinical Privileges, MMS.05 Emergency medications.

Safe and patient-centered sedation services

SAS.21 Procedural sedation techniques and management of related complications are guided by clinical protocols.

Patient-centeredness

Keywords:

Sedation Protocol

Intent:

The American College of Emergency Physicians (ACEP) defines procedural sedation as "a technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows the patient to tolerate unpleasant procedures while maintaining cardiorespiratory function. Procedural sedation and analgesia (PSA) are intended to result in a depressed level of consciousness that allows the patient to maintain oxygenation and airway control independently."

To ensure uniformity of procedural sedation services, clinical protocols shall be developed for the approved procedural sedation techniques based on professional practice guidelines. These protocols are designed according to the scope of service of the hospital and the types of surgeries and invasive procedures.

Clinical protocols shall be explained and applied by all medical staff privileged to perform procedural sedation. These protocols should also include the management of complications that could occur by providing sedation.

The hospital shall develop and implement a policy to manage procedural sedation all over the hospital to include at least the following:

- a) The locations in which procedural sedation is allowed to be performed.
- b) The competencies and privileges required for staff involved in performing or monitoring procedural sedation.
- c) Situations in which procedural sedation must be conducted by an anesthesiologist only.
- d) Sedative agents used in procedural sedation for different patient categories and reverse agents.
- e) Emergencies are expected, and the needed requirements to manage such situations include the availability of critical equipment, supplies, and medications that cover all ages.

Survey process guide:

- GAHAR surveyor may review the approved hospital policy guiding the management of procedural sedation and the sedation protocols.

- GAHAR surveyor may interview the involved staff members to assess their awareness of the hospital policy and the implementation of sedation protocols.
- GAHAR surveyor may review a sample of patients' medical records for those who received sedation to check the recorded sedation technique used.
- GAHAR surveyor may review the protocols for managing sedation complications and observe the process to check the availability of all needed tools to apply these protocols if necessary.

Evidence of compliance

1. Hospital-approved protocols for procedural sedation are used in the hospital.
2. There is an approved policy guiding the management of procedural sedation that covers elements from a) to e) in the intent.
3. The involved staff are aware of the policy requirements for procedural sedation.
4. The equipment, medications, and medical supplies needed during the sedation are readily available in the hospital.
5. The staff's competency in performing and monitoring procedural sedation is ensured.

Related standards:

MMS.06 High-alert medications and concentrated electrolytes, WFM.09 Staff Performance Evaluation, WFM.12 Clinical Privileges.

SAS.22 Pre-procedural sedation assessment and procedural sedation plan are performed by competent physicians.

Patient-centeredness

Keywords:

Sedation Plan

Intent:

Safe procedural sedation service includes multiple steps, starting with a pre-procedural sedation assessment and continuing through the administration of sedation medications until the patient safely returns to baseline condition.

The pre-procedural sedation assessment determines the patient's condition, risk scoring for receiving sedation, and required interventions/care before, during, and after receiving sedation. The hospital is required to perform a pre-procedural sedation assessment for all patients before transfer to perform the procedures. The outcome of the assessment includes the risk scoring of receiving sedation and the sedation plan.

Procedural sedation services shall be performed by a competent medical staff that includes a physician trained and certified in providing procedural sedation services and having at least basic competency in resuscitative services, provided that advanced life support is reachable within 5 minutes maximum.

Survey process guide:

- GAHAR surveyor may observe patients who received procedural sedation to evaluate the pre-procedural sedation assessment process, including its validity and the development process for procedural sedation care.
- GAHAR surveyor may review a sample of patients' medical records for those who received procedural sedation to check the pre-procedural sedation assessment and the procedural sedation plan records.

Evidence of compliance:

1. A pre-procedural sedation assessment is performed for patients before they receive procedural sedation.

2. There is a developed procedural sedation plan for patients after performing the pre-procedural sedation assessment.
3. Pre-procedural sedation assessment and the procedural sedation plan development are performed by competent physicians.
4. The pre-procedural sedation assessment and the procedural sedation plan are recorded in the patient's medical record.

Related standards:

SAS.21 Sedation Protocol, SAS.03 Assessment before surgery and invasive procedures, SAS.08 Operative Report, WFM.09 Staff Performance Evaluation, WFM.12 Clinical Privileges.

SAS.23 Continuous monitoring of the patient's physiological status during sedation is performed and recorded by a competent physician.

Safety

Keywords:

Procedural sedation physiological status monitoring, Care during procedural sedation

Intent:

Changes in sedated patients' physiologic status could be very rapid. Patient physiologic status is required to be continuously monitored starting before receiving the procedural sedation to determine the baseline of the patient's condition. This also helps in determining patient criteria for discharge from the post-procedural sedation care unit. Continuous monitoring allows the medical staff to do on-time interventions for any changes in the patient's condition. The type of monitoring is determined according to the patient's condition, age, sedation technique, type, and duration of invasive procedure based on the professional practice guidelines.

A medical staff member is required to record the implemented procedural sedation care, including the medications used, their doses, routes, and times of administration. Any unusual event that occurred during procedural sedation and its management must also be recorded.

Finally, after returning to pre-procedural sedation status, the patient's physiological status must be recorded. Medical staff member orders for patient transfer to either the post-procedural sedation care unit or intensive care unit and records the time of transfer.

The record during sedation includes at least the following:

- a) The patient's physiological status.
- b) Time of start of sedation.
- c) Sedation score.
- d) Administered medications with dose, route, and time of administration.
- e) Fluid management includes intake and output.
- f) The occurrence of any unusual event.
- g) The patient's condition before leaving the theatre.
- h) Patient disposition.
- i) Time of transfer.
- j) Signature of the physician.

Survey process guide:

- GAHAR surveyor may observe a patient receiving sedation service to evaluate the patient monitoring process and the staff involved in it.
- GAHAR surveyor may observe a patient who received the sedation service to evaluate the process of sedation care.

- GAHAR surveyor may review a sample of patients' medical records for those who received sedation to check procedural sedation records and the documented sedation care.

Evidence of compliance:

1. Patient physiologic status is monitored during procedural sedation based on professional practice guidelines.
2. Monitoring of the patient's physiologic status is performed by a competent physician.
3. Procedural sedation care is performed based on approved sedation protocols.
4. The procedural sedation record, including all elements in the intent from a) through j), is complete.
5. Procedural sedation record is kept in the patient's medical record.

Related standards:

SAS.21 Sedation Protocol, WFM.09 Staff Performance Evaluation, WFM.12 Clinical Privileges, IMT.08 Patient's Medical record Management.

SAS.24 A competent clinical practitioner performs post-procedural sedation care and continuously monitors the patient's physiological status in an appropriately equipped place.

Safety

Keywords:

Post-procedural sedation care, Post sedation monitoring.

Intent:

Procedural sedation risks may occur even during the post-procedural sedation period, so the patient should be regularly monitored. A nurse or physician trained in post-procedural sedation care shall be assigned to the post-sedation care unit/location to perform the required post-procedural sedation care for the patients.

Accordingly, there should be a post-procedural sedation care unit/location equipped with at least monitoring equipment, a source of oxygen supply, recommended medications, medical supplies, and advanced life support to be reachable.

Post-procedural sedation care includes monitoring the patient's physiologic status, allowing medical staff to intervene on time for any changes in the patient's condition, and determining the patient's criteria for discharge from the post-sedation care unit.

The type of monitoring is determined according to the patient's condition, age, sedation used, type, and duration of surgery/invasive procedure based on the professional practice guidelines. Patient monitoring is required to be done by a competent nurse or physician.

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

The hospital is required to ensure good communication between staff in different units by ensuring the recording of exceptional or unusual events that occurred inside the post-sedation care unit with provided management, the time of receiving the patient, and the time of transfer from the post-sedation unit. Post-sedation care records include at least the following:

- a) Recording the patient's physiological status.
- b) Time of receiving the patient.
- c) The occurrence of any unusual event.
- d) The patient's condition before leaving according to a defined score.
- e) Patient disposition.
- f) Time of transfer.
- g) Signature of the physician.

Survey process guide:

- GAHAR surveyor may observe the units where sedation is performed in the hospital and check the area used for post-sedation care to ensure the availability of equipment and other resources in that area.
- GAHAR surveyor may observe a patient who received sedation till the post-sedation stage (if applicable).
- GAHAR surveyor may review a sample of patients' medical records for those who received sedation to check post-sedation care records.
- GAHAR surveyor may review a sample of patients' medical records for those who received sedation to ensure that the patient's transfer/discharge decision from the post-procedural sedation area is made by a competent physician according to defined criteria.

Evidence of compliance:

1. There is a post-procedural sedation care unit/location for each department where surgery or invasive procedures are performed, and the unit/location is equipped with the required equipment.
2. A qualified healthcare professional monitors the patient's physiologic status during post-sedation care according to professional practice guidelines.
3. The provided post-procedural sedation care is recorded in the patient's medical record, including items from a) to g) in the intent.
4. A competent physician decides on the patient's transfer/discharge from the post-procedural sedation area according to defined criteria.

Related standards:

SAS.21 Sedation Protocol, IMT. 08 Patient's Medical record Management, MMS.05 Emergency medications, WFM.09 Staff Performance Evaluation, ACT.08 Handover communication.

Medication Management and Safety

Chapter intent:

Maximizing the effectiveness of medications for both patients and society is becoming increasingly crucial as the number of people taking medications continues to rise. Health services worldwide provide these medications, which play a vital role in preventing, treating, and managing numerous illnesses and conditions. Medications are the most prevalent interventions in healthcare.

Medication is defined as any prescription medications, including narcotics; herbal remedies; vitamins; nutraceuticals, over-the-counter (OTC) medications; vaccines; biological, diagnostic, and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood products; medication containing products, and intravenous solutions with electrolytes and/or medications. The definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases unless explicitly stated.

Medication management is a critical responsibility in any hospital. This complex process involves multiple phases: planning, procurement, storage, prescribing, transcribing, ordering, dispensing, administration, monitoring of medications, and program evaluation.

Evidence indicates that errors occur at each phase of the medication management cycle, adversely affecting patient safety, which is a top priority in modern healthcare. The substantial and increasing use of medications, coupled with the need to prescribe for special populations and the introduction of many new medications, brings a heightened risk of harm. This risk underscores the critical need for medication safety in the healthcare system.

Medication errors are among the most common errors in healthcare institutions, occurring at any stage of the medication management process. These errors lead to significant morbidity, resulting in high financial costs for healthcare facilities and negatively impacting patients' quality of life. Preventing medication errors is a top priority in the healthcare system, with many international organizations, including the WHO, incorporating medication safety into their global patient safety initiatives.

GAHAR sets rigorous standards for medication management to ensure safe and rational medication use in hospitals. These standards are designed to promote best practices, ensure proper medication handling, and facilitate continuous quality improvement in medication management processes.

Chapter purpose:

- 1) To ensure that medications are appropriately and effectively used during every step of the cycle, maximizing patient benefits.
- 2) To implement systems for monitoring, evaluating, and enhancing practices at each stage of the medication management cycle, fostering a culture of ongoing quality improvement.
- 3) To identify and reduce risks at each phase of the medication management cycle, thereby minimizing medication errors and adverse drug events.

MMS chapter Summary of Changes*Summary of Changes Chapter 8*

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
MMS.01 KW: Medication management	MMS.01 KW: Medication management	1- Rephrasing of EOC (EOC.02: A licensed pharmacist supervises all medication management activities, according to law and regulations.)
MMS.02 KW: Antimicrobial Stewardship Program	MMS.02 KW: Antimicrobial Stewardship Program	1- Rephrasing of standard statement to be: (Antimicrobial stewardship program is developed and implemented to enhance rational use of antimicrobials. 1- Modified EOC: (EOC.02: The hospital has an approved multidisciplinary antimicrobial stewardship program based on national and/or international core elements, and guidelines.) 2- Updated EOC (EOC.05) by merging two EOCs (EOC.05 and EOC.06) in Hospital edition 2021.
MMS.03 KW: Medication Procurement, Formulary	MMS.03 KW: Medication Procurement, Formulary	1. Rephrasing of EOCs: <ul style="list-style-type: none"> (EOC.01: The hospital has a defined process for appropriate selection and procurement of medications according to the applicable laws and regulations, hospital mission, patient needs, and services provided.) (EOC.05: The hospital has a defined process to guide the addition/deletion of medication to/from the medication list (formulary). (EOC.04: There is a process for overseeing medication use in the hospital to monitor, maintain, and update the medication list). 2. Modified EOCs: <ul style="list-style-type: none"> (EOC.02: The hospital has an approved list of medications (formulary), which includes at least items from a) to e) in the intent).
MMS.04 KW: Medication storage and labelling	MMS.04 KW: Medication storage and labelling	1) Rephrasing of standard statement to be: (Medications are stored in a manner that maintains the security and quality of the

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		medications and according to the applicable laws and regulations.).
MMS.05 KW: Emergency Medications	MMS.05 KW: Emergency Medications	No changes
MMS.06 KW: High alert medications and concentrated electrolytes	MMS.06 KW: High alert medications and concentrated electrolytes	<ol style="list-style-type: none"> 1) Modified EOC: (EOC.02: The hospital has an approved and annually updated list(s) of high-alert medications and concentrated electrolytes.) 2) Rephrasing of EOC: (EOC.05: The hospital monitors the reported data on management of high alert medications and concentrated electrolytes and take actions to control or improve the process as appropriate.)
MMS.07 KW: Look alike and Sound alike medications.	MMS.07 KW: Look alike and Sound alike medications.	<ol style="list-style-type: none"> 1) Rephrasing of EOC: (EOC.05: The hospital monitors the reported data on management of LASA and take actions to control or improve the process as appropriate).
MMS.08 KW Medication recall, expired, and outdated medication. .	MMS.08 KW: Drug recall, expired, and outdated medication.	<ol style="list-style-type: none"> 3) Rephrasing of Standard statement to be: (The hospital has a system in place for medication recall.) 4) Modified EOC: (EOC.01: The hospital has an approved policy to guide the medication recall process that includes all elements from a) through d) in the intent.) 5) Updated EOC (EOC.04) by merging two EOCs (EOC.04 and EOC.05) in Hospital edition 2021.
MMS.09 KW: Radioactive medications, contrast, narcotics, medication brought by patients.	MMS.09 KW: Radioactive medications, contrast, breast milk, medication brought by patients MMS.15	<ol style="list-style-type: none"> 2) Rephrasing of Standard statement to be: (Medications require special considerations to ensure that risk is minimized.) 3) Modified EOC: (EOC.01: The hospital has an approved policy to guide the use of medications with special consideration

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
	<p>KW: Medication dispensing, distribution system, Patient education, and counseling</p> <p>MMS.16 KW: Medication administration, order verification, medication-self administration.</p>	<p>that addresses all elements mentioned in the intent from a) through d).</p> <p>4) Added a new EOC: (EOC.04: Narcotics and psychotropic agents are procured, stored, prescribed, dispensed, administered, and monitored according to law and regulations).</p>
<p>MMS.10 KW: Medication Reconciliation, best possible medication history (BPMH)</p>	<p>MMS.10 KW: Medication Reconciliation, best possible medication history (BPMH)</p>	<p>9) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved policy for medication reconciliation that includes all elements mentioned in the intent from a) through d). • (EOC.03: Medication reconciliation occurs on situations mentioned in the intent from i) to iv) within a defined timeframe.)
<p>MMS.11 KW: Ordering, prescribing, transcribing.</p>	<p>MMS.11 KW: Ordering, prescribing, transcribing, abbreviations, and symbols</p> <p>MMS.12 KW: Complete medication order, narcotic medications, special types of medication orders</p>	<p>3) Updated standard (MMS.11) by merging two standards (MMS.11 and MMS.12) in Hospital edition 2021.</p>
<p>MMS.12 KW: Medication appropriateness review, competent pharmacist</p>	<p>MMS.13 KW: Medication appropriateness review, competent pharmacist</p>	<p>4) Rephrasing of EOC.01: (The patient-specific information, required for an effective review process, and its sources are always available and accessible,).</p> <p>5) Modified EOC: (EOC.03: Each prescription is reviewed for appropriateness before dispensing including elements a) through h) in the intent).</p>

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
MMS.13 KW: Medication preparation, medication preparation area, labeling of medications	MMS.14 KW: Medication preparation, medication preparation area, labeling of medications	1) Rephrasing of standard statement to be: (The hospital has a process to ensure safe medications' preparation).
MMS.14 KW: Medication dispensing, distribution system, patient education, and counseling.	MMS.15 KW: Medication dispensing, distribution system, patient education, and counseling.	2) Rephrasing of standard statement to be: (Medications are dispensed according to laws and regulations).
MMS.15 KW: Medication administration, order verification, medication-self administration.	MMS.16 KW: Medication administration, order verification, medication-self administration.	1) Rephrasing of standard statement to be: (Medications are administered according to laws, and regulations).
MMS.16 KW: Medication Monitoring, first dose of medications, adverse drug reaction	MMS.17 KW: Medication Monitoring, first dose of medications, adverse drug reaction	1. Rephrasing of EOC.02: (The hospital implements a process for monitoring the response to the first dose (if any) of new medications to the patient, which is expected to show noxious effects while the patient is under the hospital's direct care).
MMS.17 KW: Medication errors, near miss, medication therapy problems	MMS.18 KW: Medication errors, near miss, medication therapy problems	1. Rephrasing of EOC.03: (The hospital monitors the reported data on medication errors, near misses, and medication therapy problems, and takes actions to control or improve the process as appropriate).

Effective planning and management of medication

MMS.01 Medication management and usage are aligned with the hospital's scope of services to meet patients' needs according to the applicable laws and regulations.

Effectiveness

Keywords:

Medication management

Intent

Medication management remains a primary concern in hospitals and is an essential component in the palliative, symptomatic, and curative treatment of many diseases. The unsafe use of medication is not the only safety problem in the healthcare system, but it is certainly one of the most significant issues. Ensuring a safer medication management program in any hospital is a major challenge. Medication management processes should be implemented according to the applicable laws and regulations.

The hospital shall develop and implement a safe medication management program that addresses at least the following:

- a) Planning
- b) Selection and procurement
- c) Storage
- d) Ordering and prescribing
- e) Preparing and dispensing
- f) Administration
- g) Monitoring and evaluation

A qualified and licensed pharmacist or healthcare professional shall directly supervise the medication management program according to law and regulations. This program is a multidisciplinary effort exerted by all healthcare professionals involved in the medication management process. Usually, the medication management system is managed and updated through the Drug and Therapeutic Committee (DTC) (also known as the Pharmacy and Therapeutic Committee (PTC)). The presence of DTC with clear terms of reference is essential in the management of medication use. The DTC is involved in the development and evaluation of the medication management program. In addition, a system review shall be performed at least annually.

Survey process guide

- GAHAR surveyor may review the medication management program document, interview healthcare professionals involved in medication management, and inquire about all steps of the medication management process.
- GAHAR surveyor may review the DTC terms of reference, the meeting minutes, and the medication management program annual report.

Evidence of compliance

1. The hospital has a medication management and safety program according to the applicable laws and regulations that address all elements from a) through g) in the intent.
2. A licensed pharmacist supervises all medication management activities according to law and regulations.
3. The hospital has a drug and therapeutic committee (DTC) with a clear term of reference. The committee is involved in the development and ongoing evaluation of the medication management and safety program.
4. Updated and appropriate medication-related information source(s) are available to those involved in medication management either electronically or in paper form.
5. There is an annual documented review of the medication management and safety program, addressing elements from a) through g) in the intent as appropriate.

Related standards

MMS.03 Medication Procurement, Formulary, MMS.04 Medication storage and labelling, MMS.11 Ordering, prescribing, transcribing, MMS.13 Medication preparation, medication preparation area, labeling of medications, MMS.14 Medication dispensing, distribution system, patient education, and counseling, MMS.15 Medication administration, order verification, medication-self administration, WFM.04 Job Description

MMS.02 Antimicrobial stewardship program is developed and implemented to enhance rational use of antimicrobials.

Safety

Keywords:

Antimicrobial Stewardship Program

Intent:

Due to repeated antimicrobial prescriptions for doubtful indications and for longer than necessary, antimicrobial resistance is acquired, which can negatively impact patient outcomes and pose a significant threat to patient safety.

Antimicrobial stewardship is the effort to promote the optimal use of antimicrobial agents, reduce the transmission of infections, and educate healthcare professionals, patients, and the public. Implementation of an antimicrobial stewardship program (ASP) will facilitate the development and spread of resistant bacteria and deliver better patient outcomes.

ASP is an organizational priority that requires leadership commitment and support. Leadership support examples include accountability documents, dedicating necessary resources, plans for infection prevention, performance improvement, strategic plans, and using the patient's medical record to collect antimicrobial stewardship data. It is also important to appoint a leader responsible for program outcomes.

An effective ASP will implement at least one intervention that meets a need within the hospital. A stepwise implementation approach will help familiarize staff with the new policies and procedures. Interventions may include the following:

- The development and implementation of clinical guidelines based on local, national, or international data (management of urinary tract infections, respiratory tract infections, etc.).
- Prophylactic use of antibiotics in surgery.
- Restricting the use of certain antimicrobial agents based on the spectrum of activity or cost.
- Preauthorization, de-escalation of empirical antimicrobial therapy, or the alteration of antimicrobial therapy once culture (if applicable) results become available.
- The development of clinical criteria and guidelines for switching from parenteral to oral agent.
- Detection and prevention of antibiotic-related drug-drug interactions can also be implemented.

The decision to select which intervention to implement shall be based on staffing, patient population, clinical culture, and resources.

Tracking the program's effectiveness is important to assess, monitor, and improve the program. Examples of program evaluation include:

- Evidence of a decrease in the inappropriate use of antimicrobials.
- Collecting data on adherence to antibiotic prescribing policies and antibiotic use.
- Tracking the appropriate use of prophylactic antibiotics.
- Measurement of antimicrobial consumption and cost (e.g., using defined daily doses (DDD) or days of therapy (DOT)).
- Collecting data on resistance patterns in the hospital.

It is important to ensure that antimicrobial stewardship reports are regularly available to leadership and healthcare professionals, which serves as a reminder of the program's importance. Educating healthcare professionals, patients, and their families on optimal antimicrobial use, antimicrobial resistance, and antimicrobial stewardship practices is also important.

Survey process guide:

- GAHAR surveyor may review the antimicrobial stewardship program document.
- GAHAR surveyor may interview the healthcare providers to assess their awareness of any activity related to the antimicrobial stewardship program.
- GAHAR surveyor may trace the prescription of antimicrobial agents and follow the process steps for selecting, ordering, dispensing, administering, and monitoring the agent.

Evidence of compliance:

1. The antimicrobial stewardship program is a hospital priority with leadership commitment and support.
2. The hospital has an approved multidisciplinary antimicrobial stewardship program based on national and/or international core elements and guidelines.
3. The hospital educates staff, patients, and their families about antimicrobial stewardship practices and the appropriate use of antimicrobials.
4. The antimicrobial stewardship program uses hospital-approved interdisciplinary protocols.
5. The hospital monitors the reported data on its antimicrobial stewardship program and takes actions to control or improve the process as appropriate.

Related standards:

MMS.01 Medication management, IPC.02 IPC program, risk assessment, guidelines, IPC.19 Multi-Drug Resistant Organisms.

Efficient medication selection and procurement

MMS.03 Hospital medications are selected, listed, and procured based on approved criteria.

Efficiency

Keywords:

Medication Procurement, Formulary

Intent:

Medication selection and procurement is an interdisciplinary process, and it involves (if not being done through higher authority outside the hospital) efforts to quantify medication requirements, select appropriate procurement methods, and prequalify suppliers and products. It also involves managing tenders, establishing contract terms, assuring medication quality, and obtaining the best prices. It is performed based on a transparent process according to applicable laws and regulations.

The hospital (represented by the drug and therapeutic committee) shall develop a list (known as a formulary) of all the medications it stocks. A formulary is selected based on disease prevalence, evidence of efficacy, safety, and comparative cost-effectiveness. Laws and regulations may determine the medications on the list. The formulary shall include (but not limited to):

- a) Names of medications,
- b) Strengths/concentrations of medication(s),
- c) Dosage forms of the medication(s),
- d) Indications for use,
- e) Risks/side effects of the medications.

Updating the medication list is guided by criteria (e.g., indications for use, effectiveness, drug interactions, adverse drug events, sentinel events, and population(s) served (e.g., pediatrics, geriatrics). The hospital develops and implements a process to evaluate the medication use in the hospital to monitor and update the medication list (e.g., ABC analysis, vital/essential/nonessential, and (VEN) analysis). Evaluation of medications, intending to add or delete them from the formulary, is a necessary criterion for formulary update and maintenance.

Survey process guide:

- GAHAR surveyor may review the hospital formulary and check for its availability.
- GAHAR surveyor may interview the DTC members about the process of adding/deleting medication to/from the hospital formulary.
- GAHAR surveyor may ask about the action taken in case of medication shortage.

Evidence of compliance:

1. The hospital has a defined process for the appropriate selection and procurement of medications according to the applicable laws and regulations, hospital mission, patient needs, and services provided.
2. The hospital has an approved list of medications (formulary), which includes at least items from a) to e) in the intent.
3. A controlled printed and/or electronic formulary copy of the approved medications shall be readily available and accessible to all those involved in medication management.
4. There is a process for overseeing medication use in the hospital to monitor, maintain, and update the medication list.
5. The hospital has a defined process to guide the addition/deletion of medication to/from the medication list (formulary).
6. The hospital has an approved process for properly communicating medication shortages and outages to prescribers and other healthcare professionals.

Related standards:

MMS.01 Medication management, MMS.04 Medication storage and labeling, MMS.08 Medication recall, expired, and outdated medication, OGM.10 Supply Chain Management.

Safe medication storage

MMS.04 GSR.19 Medications are stored in a manner that maintains the security and quality of the medications and is according to the applicable laws and regulations.

Safety

Keywords:

Medication storage and labeling

Intent:

Appropriate storage of medications can reduce waste, incorrect medication dispensing and handling, and the incidence of missed doses. Medications are usually stored in pharmacies, storage areas, or patient care areas in the hospital according to the manufacturer's recommendation and according to the applicable laws and regulations.

The stability/effectiveness of some medications depends on storing them in the correct conditions, such as light, humidity, and temperature. The hospital shall maintain appropriate storage conditions in medication storage areas to protect the stability of medications (temperature, light, humidity) 24 hours a day, seven days a week.

The hospital shall limit access to medication storage areas with the level of security required to protect it against loss or theft, depending on the types of medications stored.

Labeling 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 drugs. 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, yet it is routine in many hospitals.

Medications, medication containers, other solutions, and the components used in their preparation are clearly labeled (if not clearly shown in the original packages or boxes) with the name, concentration/ strength, expiration date, batch number, and any applicable warnings.

Survey process guide:

- GAHAR surveyor may observe the medication storage and preparation areas, including areas in perioperative and procedural settings, to assess storage conditions and labeling.

Evidence of compliance:

1. Medications are safely and securely stored according to the manufacturer/marketing authorization holder's recommendations and kept clean and organized.
2. The hospital has an approved process for the use and storage of multi-dose medications to ensure their stability and safety.
3. The hospital has a clear process to deal with an electric power outage to ensure the integrity of any affected medications before use.
4. Medications in stores, pharmacies, and patient care areas are periodically (at least monthly) inspected to confirm compliance with proper storage conditions.
5. Medications, medication containers, other solutions, and the components used in their preparation are clearly labeled (if not clearly shown in the original packages or boxes) with the name, concentration/ strength, expiration date, batch number, and any applicable warnings.

Related standards:

MMS.01 Medication management program, MMS.06 High-alert medications and concentrated electrolytes, MMS.07 Look-alike and Sound like medications., EFS.11 Utility Management, MMS.08 Medication recall, expired, and outdated medication.

MMS.05 Emergency medications are available, accessible, and secured at all times.

Safety

Keywords:

Emergency Medications

Intent:

When a patient emergency occurs, quick access to emergency medications is critical and may be lifesaving. Emergency medications shall be readily accessible and uniformly stored to facilitate quick access to the proper medication to meet emergency needs. For example, in each emergency cart in the hospital, emergency medications are in the same drawer and laid out in the same manner within the drawer of each cart.

The hospital shall develop and implement a policy and procedures to ensure the availability of emergency medications in patient care areas that address at least the following:

- a) Emergency medications should be readily accessible and uniformly stored.
- b) Prevention of abuse, loss, or theft of emergency medications to ensure their availability when needed.
- c) Replacement of emergency medication at the most appropriate time when used, damaged, or outdated.

Survey process guide:

- GAHAR surveyor may review the hospital policy for emergency medication management.
- GAHAR surveyor may interview staff members who are responsible for emergency medication storage to inquire about storage conditions, accessibility, storage security, and replacement of medications when needed.
- GAHAR surveyor may observe emergency medication storage areas.

Evidence of compliance:

1. The hospital has an approved policy to guide emergency medication availability that addresses at least all elements mentioned in the intent from a) through c).
2. Emergency medications are appropriately available and accessible to the clinical areas when required.
3. Emergency medications are uniformly stored in all locations.
4. Emergency medications are replaced within a predefined timeframe when used, damaged, or outdated.

Related standards:

CSS.05 Cardiopulmonary resuscitation, MMS.01 Medication management program, MMS.03 Medication Procurement, Formulary, MMS.04 Medication storage and labelling.

MMS.06 GSR.20 High-Alert medications and concentrated electrolytes are identified, stored, and dispensed in a way that assures that risk is minimized.

Safety

Keywords:

High-alert medications and concentrated electrolytes

Intent:

High-alert medications are those that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more familiar with these medications, the consequences of an error are clearly more devastating to patients. Examples of high-alert medications include but are not limited to, anticoagulants, hypoglycemic agents, medications with a narrow therapeutic range, anesthesia medications, and inotropic agents.

Concentrated electrolytes include, but are not limited to, potassium chloride [equal to or greater than two mEq/mL concentration], potassium phosphate [equal to or greater than three mmol/mL concentration], and magnesium sulfate [equal to or greater than 50% concentration]. There are several reports of accidental deaths due to the inadvertent administration of concentrated electrolytes. Avoiding storage of concentrated electrolytes in patient care areas is one method to minimize the risk of death or injury associated with these medications.

The hospital shall develop and implement a policy and procedures to guide the process of safe use of high-alert medications and concentrated electrolytes that address at least the following:

- a) Lists of high-alert medications and concentrated electrolytes based on the hospital's own data and both national and internationally recognized organizations (e.g., Institute of Safe Medication Practice (ISMP) and the World Health Organization (WHO)).
- b) Strategies are in place to prevent the inadvertent use of these medications.
- c) A uniform process for the safe storage and administration of high-alert medications and concentrated electrolytes

Survey process guide:

- GAHAR surveyor may review the hospital policy that guides the process of safe use of high-alert medications.
- GAHAR surveyor may observe patient care areas and assess measures to ensure the safe storage of high-alert medications (such as being labeled) and concentrated electrolytes (such as being removed whenever possible, labeled with a warning reminder, or separated in secure areas).
- GAHAR surveyor may interview pharmacists/nurses at different patient care areas to assess their understanding of preventive strategies for managing these medications and concentrated electrolytes.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements from a) through c) in the intent
2. The hospital has an approved and annually updated list(s) of high-alert medications and concentrated electrolytes.
3. The hospital implements process(es) to prevent inadvertent use of high-alert medications and concentrated electrolytes.
4. The hospital trains healthcare professionals involved in the management and use of high-alert medications and concentrated electrolytes.
5. The hospital monitors the reported data on the management of high-alert medications and concentrated electrolytes and takes actions to control or improve the process as appropriate.

Related standards:

MMS.04 Medication storage and labelling, MMS.13 Medication preparation, medication preparation area, labeling of medications, MMS.15 Medication administration, order verification, medication-self administration, MMS.17 Medication errors, near miss, medication therapy problems.

MMS.07 GSR.21 Look-alike and sound-alike medications are identified and stored in a manner to minimize the risk of medication dispensing and administration errors.

Safety

Keywords:

Look-alike and Sound like medications.

Intent:

Look-alike sound-alike (LASA) medications are those visually similar in physical appearance or packaging and names of medications with 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.

One strategy that ISMP recommends for reducing LASA medication errors is to include both the brand and non-proprietary names, dosage forms, strengths, directions, and the indication for use to help differentiate LASA medication names. If LASA medications have different indications, associating an indication with a medication may help differentiate it from another with a similar-sounding name. Other recommendations focus on ensuring prescription legibility through improved handwriting and printing. Some hospitals may use physical separation and segregation of these medications in medication storage areas to minimize the risk.

In addition, some hospitals use specially designed labels or “tall man” (mixed case) lettering (e.g., DOPamine versus DoBUTamine) to emphasize drug name differences.

The hospital develops a risk management strategy to minimize adverse events with LASA medications and enhance patient safety.

The hospital shall develop and implement a policy and procedure to ensure the safety of LASA that includes at least the following:

- a) List of Look-alike Sound-alike medications
- b) Storage requirements
- c) Labeling requirements
- d) Dispensing requirements

Survey process guide:

- GAHAR surveyor may review the hospital policy that guides the process of safe use of LASA medications.
- GAHAR surveyor may review the hospital's updated list of look-alike and sound-alike medications.
- GAHAR surveyor may Interview pharmacists and nurses to inquire about processes to minimize

the risk of using look-alike sound-alike medications.

- GAHAR surveyor may observe the pharmacy, medication carts, medication storage, and medication preparation areas to check the labeling of LASA medications.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements from a) to d) in the intent.
2. There is an approved list of LASA medications that is updated at least annually.
3. The hospital provides training to the healthcare professionals involved in the management and use of LASA.
4. LASA medications are stored, segregated, and labeled safely and uniformly in all locations.
5. The hospital monitors the reported data on the management of LASA and takes actions to control or improve the process as appropriate.

Related standards:

APC.03 Sustaining compliance with accreditation standards, MMS.04 Medication storage and labelling, MMS.13 Medication preparation, medication preparation area, labeling of medications, MMS.15 Medication administration, order verification, medication-self administration, MMS.17 Medication errors, near miss, medication therapy problems.

MMS.08 The hospital has a system in place for medication recall.

Safety

Keywords:

Medication recall, expired, and outdated medication.

Intent:

The great benefits derived from medications are also accompanied by many risks, which may be derived from the properties of the drug substance, the quality of the medications, or, in some cases, the product's defectiveness.

When safety issues arise, a medication recall is required, and defective products must be returned to the manufacturer/distributor. This includes expired, outdated, damaged, or contaminated medications. It also includes sterile and non-sterile compounded preparations in which recalled medications/ingredients have been used in their preparation.

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

The hospital must have a process in place for the proper identification and retrieval of medications recalled by the local health authorities, the manufacturer, or other well-recognized bodies. The hospital shall develop and implement a policy and procedures to guide the process of managing recalled medication. It ensures that expired medications cannot be inadvertently distributed, dispensed, or administered that addresses at least the following:

- a) Process to retrieve recalled medications.
- b) Labelling and separation of recalled medications.
- c) Patient notification (when applicable).
- d) Disposal or removal.

Survey process guide:

- GAHAR surveyor may review the hospital policy followed by interviewing pharmacists and nurses to inquire about processes to manage recalled, expired, outdated, damaged, dispensed but not used, and/or contaminated medications.
- GAHAR surveyor may observe the pharmacy, medication carts, medication storage, medication preparation, and patient care areas to check for the presence of recalled, expired, outdated, damaged, dispensed but not used, and/or contaminated medications.
- GAHAR surveyor may request to trace a recalled medication from the reception of the medication recall notice till disposal or removal.

Evidence of compliance:

1. The hospital has an approved policy to guide the medication recall process, including all elements from a) through d) in the intent.
2. Staff members involved in the medication recall process are aware of the policy requirements.
3. Recalled medication(s) is/are retrieved, labeled, separated, and disposed of (or removed) safely.
4. Expired, outdated, damaged, and/or contaminated medications are stored, disposed, or removed according to the policy.

Related standards:

MMS.01 Medication management program, MMS.04 Medication storage and labelling.

MMS.09 Medications require special considerations to ensure that risk is minimized.

Safety

Keywords:

Radioactive medications, contrast, narcotics, and medication brought by patients.

Intent

Some medications and nutrition products pose a challenge in their identification/labeling, storage, and control of use. They require special process(es) for handling. These medications include but are not limited to contrast media, radiopharmaceuticals, narcotics, and medications brought by patients. The hospital shall identify medications that may pose a challenge in their management.

The hospital shall develop and implement a policy and procedures to guide the process of handling and management of these medications (narcotics, contrast media, radiopharmaceuticals, medications brought by patients) that address at least the following:

- a) Receipt
- b) Identification and labeling
- c) Storage
- d) Administration

Survey process guide:

- GAHAR surveyor may review the hospital policy followed by interviewing pharmacists, nurses, radiology technicians, and other healthcare professionals to inquire about processes for managing these medications.
- GAHAR surveyor may observe the pharmacy medication storage, medication preparation, and patient care areas, including radiology, maternal, and childcare areas, to assess the identification, labeling, storage, and administration of these medications.

Evidence of compliance:

1. The hospital has an approved policy to guide the use of medications with special consideration that addresses all elements mentioned in the intent from a) through d).
2. Staff members involved in managing medications with special consideration demonstrate knowledge of the procedures.
3. Contrast media and radiopharmaceuticals are received, identified, labeled, stored, and administered safely.
4. Narcotics and psychotropic agents are procured, stored, prescribed, dispensed, administered, and monitored according to law and regulations.
5. Medications brought by patients are received, identified, labeled, stored, and administered safely.

Related standards:

MMS.04 Medication storage and labelling, EFS.01 Hospital environment and facility safety management, EFS.11 Utility Management.

MMS.10 GSR.18 Medications are reconciled across all interfaces of care in the hospital.

Safety

Keywords:

Medication Reconciliation, best possible medication history (BPMH)

Intent:

Patients often receive new medications or have changes made to their existing medications at times of transition in care (hospital admission, transfer from one unit to another during hospitalization, discharge from the hospital, or during receiving ambulatory care services).

As a result, the new medication regimen prescribed at 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 medication reconciliation process requires developing a list of current medications and medications to be prescribed, comparing the medications on the two lists, and making clinical decisions based on the comparison.

The medication reconciliation process is a multidisciplinary activity with responsibilities shared among physicians, nurses, pharmacists, and other clinicians involved in the patient's care.

The hospital shall develop and implement a policy and procedures to guide the medication reconciliation process that addresses at least the following:

- a) Situations where medication reconciliation is required:
 - i. On admission (matching the current medication orders with the best possible medication history (BPMH) before ordering any new medication.
 - ii. During the episode of care (verifying that the current list of medications is accurately communicated each time care is transferred and when medications are recorded).
 - iii. On discharge (checking that medications ordered on the discharge prescription match those prescribed before and during the episode of care).
 - iv. During ambulatory care services (if it involves medication) before prescribing.
- b) Identify the responsibility of performing medication reconciliation.
- c) Patients and family involvement.
- d) Steps of the medication reconciliation process such as collecting the list of both prescribed and non-prescribed medications (e.g., vitamins, nutritional supplements, over-the-counter drugs, and vaccines) used by patients, clarification whether these medications and their dosages are appropriate, matching with a new list of medication and recording changes.

Survey process guide:

- GAHAR surveyor may review the hospital policy and interview medical staff members, pharmacists, and nurses to inquire about the medication reconciliation process.
- GAHAR surveyors may review a sample of patients' medical records to assess the recording of current medications upon admission.
- GAHAR surveyor may interview an appropriate number of patients to inquire about medication history assessment.
- GAHAR surveyor may check whether the patient's own medications match the recorded current medications upon admission and are included in the medication reconciliation process.

Evidence of compliance:

1. The hospital has an approved policy for medication reconciliation that includes all elements mentioned in the intent from a) through d).
2. Staff responsible for reconciling medications are trained to take the best possible medication history (BPMH) and reconcile medications.
3. Medication reconciliation occurs in situations mentioned in the intent from i) to iv) within a defined timeframe.

4. Medication prescribers compare the list of current medications with the list of medications to be prescribed and make clinical decisions based on the comparison.
5. Reconciled medications are clearly recorded, and related information is clearly communicated to healthcare professionals involved in the patient's medication prescribing.

Related standards:

PCC.07 Patient and family education process, ACT.08 Handover communication, ACT.07 Patient's care responsibility, ICD.06 Medical patient assessments, ACT.14 Patient's referral, transfer, temporary discharge, and discharge.

MMS.11 Medication ordering, prescribing, and transcribing processes follow laws and regulations.

Safety

Keywords:

Ordering, prescribing, transcribing.

Intent:

When prescribed and used effectively, medications have the potential to significantly improve quality of life, patient safety, and outcomes. However, the challenges associated with prescribing the right medications, transcribing them, and supporting patients' effective use should not be underestimated. Treating a patient with medication(s) requires specific knowledge and experience.

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

The hospital shall develop and implement a policy and procedures to guide the processes of ordering, prescribing, and transcribing medications that address at least the following:

- a) Identify who is authorized to prescribe which type of medications.
- b) Uniform location in the patient's medical record to order/prescribe medications.
- c) The limited situation(s) where the transcription process is necessary and cannot be avoided.
- d) The process of discontinuing medication order/prescription.
- e) The minimum required elements of complete medication prescriptions include:
 - i. Patient identifications
 - ii. Patient demographics include weight and height
 - iii. Drug name
 - iv. Dosage form
 - v. Strength or concentration
 - vi. Dosage, frequency, and duration
 - vii. Route of administration
 - viii. Rates of administration (when intravenous infusions are ordered)
 - ix. Indications for use, maximum frequency, and maximum daily dose for PRN orders.
 - x. Date and time of the order
 - xi. Physician's identification
- f) The process to manage special types of orders, such as weight-based dosing, standing orders, emergency orders, or orders that need titration, tapering, or range doses orders.
- g) Process to manage medication orders that are incomplete, illegible, or unclear medication orders.

Survey process guide:

- GAHAR surveyor may review the hospital policy followed by interviewing medical staff members, pharmacists, and nurses to inquire about the prescription/order process in any location, including inpatient wards, radiology areas, emergency rooms, and post-anesthesia care units.
- GAHAR surveyor may review the patient's medical records to assess the completion, legibility, and clarity of medication orders.

Evidence of compliance:

1. The hospital has an approved policy to guide the processes of ordering/prescribing and transcribing medications that address all elements mentioned in the intent from a) through g).
2. Involved staff are aware of the contents of the policy.
3. Medication prescriptions are complete and recorded for each patient, including elements from i) to xi) in the intent, as applicable.
4. Special types of orders, such as weight-based dosing, standing orders, emergency orders, and orders requiring titration, tapering, or range doses, are prescribed according to the policy.
5. Incomplete, illegible, or unclear prescriptions are managed according to hospital policy.

Related standards:

APC.03 Sustaining compliance with accreditation standards, MMS.04 Medication storage and labelling, ACT.03 Patient identification, IMT.04 abbreviations, ICD.17 Orders and requests.

Safe medication preparation and dispensing

MMS.12 Medication prescriptions are reviewed for accuracy and appropriateness.

Safety

Keywords:

Medication appropriateness review, competent pharmacist

Intent:

Dispensing is a core clinical activity that enables pharmacists to ensure the safety and effectiveness of medications.

All medication orders are reviewed for accuracy and appropriateness before dispensing or removal from floor stock. The appropriateness review is performed by competent individual(s) (e.g., clinical pharmacist).

Each newly prescribed medication is reviewed for the following elements (when applicable):

- a) The suitability of the medication regarding the indication.
- b) The dosage regimen, including the dose, frequency, route of administration, and duration of treatment, considering the patient's physiological information.
- c) Therapeutic duplication.
- d) Variation from the hospital criteria for use.
- e) Contraindications.
- f) Real or potential allergies/sensitivities.
- g) Real or potential interactions between the medication and other medications or food.
- h) Potential toxicity.

A new appropriateness review is performed when the dosage or other appropriateness factors are noted before changes; for example, therapeutic duplication may be an issue when a new medication is prescribed. The hospital defines the patient-specific information required for the appropriateness review of the prescription.

Appropriateness reviews should be conducted even when circumstances are not ideal, for example, if the pharmacy is not open and the medication is to be dispensed from stock in the nursing unit. The full appropriateness review is performed within 24 hours of dispensing the first dose.

The hospital is responsible for identifying those healthcare providers (qualified, competent, and trained pharmacists) permitted to conduct appropriateness reviews and provide them with current and updated resources to facilitate the review process.

Survey process guide:

- GAHAR surveyor may interview pharmacists, nurses, and other healthcare professionals involved in the appropriateness review to inquire about the process and its variations and may

observe the process.

Evidence of compliance:

1. The patient-specific information required for an effective review process and its sources are always available and accessible.
2. Healthcare professionals permitted to perform appropriateness reviews are competent.
3. Each prescription is reviewed for appropriateness before dispensing, including elements a) through h) in the intent.
4. When an on-site licensed, competent pharmacist is unavailable, a trained healthcare professional determined by the hospital will review critical elements f) through h) in the intent using current and updated resources.
5. There is a process to contact the prescriber when questions or concerns arise.

Related standards:

MMS.11 Ordering, prescribing, transcribing, MMS 14 Medication dispensing, distribution system, patient education, and counseling.

MMS. 13 The hospital has a process to ensure safe medication preparation.

Safety

Keywords:

Medication preparation, medication preparation area, labeling of medications.

Intent:

A safe, clean, and organized working environment provides the basis for appropriate medication preparation practice. This includes qualified/trained staff, appropriate physical surroundings, adequate shelving and storage areas, proper work surfaces, suitable equipment, and necessary packaging materials.

The hospital identifies the standards of practice for a safe preparation environment.

Healthcare professionals who prepare medications are requested to use techniques to ensure accuracy (e.g., calculation double-checking) and avoid contamination, including using clean or aseptic techniques, as appropriate, and maintaining clean and uncluttered areas for product preparation. Healthcare professionals preparing compounded sterile products or preparing medications using multi-dose vials are trained in the principles of medication preparation and aseptic technique. Similarly, laminar airflow hoods are available and used when indicated by professional practices (e.g., cytotoxic medications).

Medications are labeled in a standardized manner. This requirement shall be applied to any medication that is prepared but not administered immediately (It does not apply to a medication prepared and administered immediately).

At a minimum, labels must include the following (if any is not apparent from the medication container):

- a) Patient identifications (2 unique identifiers),
- b) Medication name,
- c) Strength/concentration,
- d) Expiration date or beyond use date (for opened medication(s) or compounded preparations),
- e) Directions for use,
- f) Any special/cautionary instructions (if any),
- g) The diluent for all compounded intravenous (IV) admixtures, and parenteral solutions (if available), and
- h) Date of preparation

Survey process guide:

- GAHAR surveyor may observe the pharmacy, medication preparation, and patient care areas, including inpatient wards, procedure areas, and operation rooms, to assess the preparation and labeling of medications.
- GAHAR surveyor may interview pharmacists, nurses, and other healthcare professionals involved in medication preparation to inquire about preparation processes and may observe the process.

Evidence of compliance:

1. Medications are prepared in clean, uncluttered, and separate areas, provided with appropriate medical equipment and supplies, and complying with the applicable professional standards of practice.
2. The hospital identifies those healthcare professionals authorized to prepare medications in different situations.

3. The hospital has a system for safely providing medications to meet patient needs when the pharmacy is closed.
4. The hospital implements a process to guide the compounding and preparation of sterile and non-sterile preparations.
5. All medications prepared in the hospital are correctly labeled in a standardized manner with the applicable elements from a) to h) in the intent.

Related standards:

ACT.03 Patient identification, MMS.11 Ordering, prescribing, transcribing, EFS.07 Safety Management Plan, IPC.04 Hand Hygiene, IPC.05 PPE guidelines, Physical Barriers, MMS.04 Medication storage and labelling.

MMS.14 Medications are dispensed according to laws and regulations.

Safety

Keywords:

Medication dispensing, distribution system, patient education, and counseling.

Intent:

Dispensing medications within the hospital follows standardized processes to ensure patient safety. A uniform system for dispensing and distributing medications can help to reduce the risk of medication errors.

The hospital dispenses medications in the most ready-to-administer form possible to minimize opportunities for error during distribution and administration.

Medications are dispensed in quantities enough to meet the patient's needs but at the same time to minimize diversion (i.e., quantities dispensed are not excessive to permit diversion). -

The hospital educates patients and their families so that they have the knowledge and skills to participate in and make decisions related to patient care processes. This education (especially on patients' discharge) includes, but is not limited to, a pharmacist's verbal explanation to patients and their families on the storage, safe and effective use, and administration of the prescribed medications.

Survey process guide:

- GAHAR surveyor may interview pharmacists, nurses, and other healthcare professionals involved in medication dispensing to inquire about the process and its variations and may observe the process.
- GAHAR surveyor may interview a patient and/or a family member to inquire about the medication education process.

Evidence of compliance:

1. The hospital is responsible for identifying healthcare professionals permitted by law and regulation, as well as their qualifications, training, experience, and job descriptions, to dispense medications.
2. The hospital has a uniform medication dispensing and distribution system according to applicable laws and regulations.
3. Medications are dispensed in the most ready-to-administer form and quantities consistent with the patient's needs and conditions.
4. Hospital pharmacy has a process for providing medication education and counseling (when applicable) to patients and/or their families, especially on patients' discharge. Patients are given

a chance to ask questions.

Related standards:

MMS.11 Ordering, prescribing, transcribing, ICD.15 Plan of Care, MMS.12 Medication appropriateness review, competent pharmacist, PCC.07 Patient and family education process.

Safe medication administration

MMS.15 Medications are administered according to laws, and regulations.

Safety

Keywords:

Medication administration, order verification, medication-self administration.

Intent:

Medication administration to manage a patient requires specific knowledge and experience. In addition, medications administered within the hospital follow standardized processes to ensure appropriateness, effectiveness, and safety of medication based on prescription or order.

The safe administration of medications includes verifying the following:

- a) Presence of medication order
- b) Patient identifications (2 unique identifiers)
- c) Right medication
- d) Reasons/indications for prescribing medication
- e) Right dosage amount and regimen
- f) Right route of administration
- g) Right time and frequency of administration
- h) Review if the patient is allergic to any medication in the prescription or order.

The hospital should identify those healthcare professionals, by law and regulation, qualification, training, experience, and job description, authorized to administer medications and admixtures, with or without supervision.

Self-administration of medications is clearly defined (e.g., use of inhalers, self-administration of insulin, insertion of suppositories/vaginal pessaries) if approved, known to the patient's physician, supervised, and noted in the patient's medical record. The processes of self-administration of medications, if allowed, should assure the competency of the patient (or, in the case of pediatrics, the patient's parents/guardians) and safety of administration by providing education to the patient about medications, dose, frequency, route, indications, and possible side effects.

Survey process guide:

- GAHAR surveyor may interview pharmacists, nurses, other healthcare professionals, patients, and their families involved in medication administration to inquire about the process and its variations. This can occur in any location, including inpatient wards, emergency room observation areas, and procedure areas.
- GAHAR surveyor may observe the process of medication administration.

Evidence of compliance:

1. The hospital identifies those healthcare professionals authorized to administer medications and admixtures, with or without supervision, by law and regulation, qualification, training, experience, and job description.

2. Medication administration includes a process to verify elements addressed in the intent from a) to h) in the intent.
3. Patients are informed about the medications they will be given, including any potential adverse drug reactions or other concerns about administering medication, and are given a chance to ask questions.
4. Medications administered, refused, or omitted are recorded in the patient's medical record.
5. The hospital implements a process that guides the safe and accurate self-administration of medications or administration of medications by a person who is not a staff member (If allowed) and addresses training, supervision, and administration documentation.

Related standards:

PCC.07 Patient and family education process, ACT.03 Patient identification, ICD.15 Plan of care, MMS.11 Ordering, prescribing, transcribing.

Effective medication monitoring

MMS.16 Medication effect(s) on patients is/are monitored.

Safety

Keywords:

Medication Monitoring, first dose of medications, adverse drug reaction

Intent:

Medication monitoring is a multidisciplinary process where the patient and their physician, pharmacist, nurse, and other healthcare professionals collaborate to monitor patients on medications.

The purpose of monitoring is to evaluate the therapeutic response of the medication(s), including safety and effectiveness, adjust the dosage or type of medication when required, evaluate for any medication interaction, and evaluate the patient for adverse effects or allergic reactions.

Medications are monitored for patient clinical effectiveness and adverse medication effects to ensure that medication therapy is appropriate, and risks are minimized.

The record of each patient who receives medications in the hospital contains a list of the current medications prescribed or ordered. This list facilitates monitoring all the medications a patient may currently be taking.

Monitoring medication effects includes observing and recording any adverse effects. This is done using a standardized reporting format and educating staff on the process and the importance of reporting. Reporting to the authorized institutions is done at the most appropriate time without any delay as per national/international regulations.

Survey process guide:

- GAHAR surveyor may interview medical staff members, pharmacists, nurses, other healthcare professionals, patients, and their families involved in medication administration to inquire about the process of medication monitoring; this can occur in any location, including inpatient wards, radiology areas, and procedure areas.
- GAHAR surveyor may review the process of reporting adverse drug events.

Evidence of compliance:

1. The patient's response to their medication is monitored according to their clinical conditions/status.
2. The hospital implements a process for monitoring the response to the first dose (if any) of new medications to the patient, which is expected to show noxious effects while the patient is under

- the hospital's direct care.
3. Actual or potential medication adverse drug effects on patients are monitored and documented in the patient's record, including the action(s) to be taken in response.
 4. Adverse drug events (ADEs) are reported in a manner consistent with national and international guidelines.
 5. The hospital implements a process for informing the prescriber when an adverse effect(s) occurs.

Related standards:

PCC.07 Patient and family education process, QPI.10 Incident Reporting System, QPI.11 Sentinel events, MMS.17 Medication errors, near misses, medication therapy problems.

MMS.17 Medication errors, near misses, and medication therapy problems are detected, reported, and acted upon.

Safety

Keywords:

Medication errors, near misses, medication therapy problems

Intent:

Given the large and growing global volume of medication use, medication errors, and near misses are particularly important. Medication errors can occur at several different stages of the medication prescription and use process. Although serious errors are relatively rare, the absolute number is sizeable, with the potential for considerable adverse health consequences.

Each hospital can have a system for detecting and reporting medication errors, near misses, and medication-related problems (also known as drug therapy problems). This system focuses on preventing and managing medication errors and near misses or any other safety issues, including but not limited to overdose, toxicity, misuse, abuse, occupational exposure, medication exposure during pregnancy, and lactation.

Each hospital shall develop a process for identifying and reporting medication errors and near misses. The process includes defining a medication error and near miss, using a standardized format for reporting, and educating staff on the process and importance of reporting.

Definitions and processes are developed through a collaborative process that includes all those involved in the different steps in medication management. The reporting process shall be part of the hospital quality improvement and patient safety program.

Medication errors, near misses, and medication therapy problems are identified and reported to the following:

- a) Prescriber and/or another healthcare professional (as required)
- b) Pharmacy and therapeutics committee
- c) Quality department/committee
- d) Leaders of the hospital (If not represented in points b or c).
- e) Authorized institutions, according to national/international regulations.

The hospital shall establish performance indicators related to medication safety, such as medication error rates, adherence to medication protocols, and the frequency of adverse drug events. It shall monitor and analyze these metrics to identify trends, improvement areas, and intervention opportunities.

Survey process guide:

- GAHAR surveyor may interview healthcare professionals involved in medication management

processes during the medication management review session and inquire about the detection, analysis, reporting, and actions of medication errors, near misses, and medication therapy problems.

Evidence of compliance:

1. The hospital has an approved policy to guide the process of defining, reporting, analyzing, and acting on medication errors, near misses, and medication therapy problems based on national/international references.
2. The hospital implements a process for detecting and reporting to bodies from a) to e) identified in the intent and acting on medication errors, near misses, and medication therapy problems.
3. The hospital monitors the reported data on medication errors, near misses, and medication therapy problems and takes actions to control or improve the process as appropriate.

Related standards:

ACT.07 Patient's care responsibility, QPI.10 Incident Reporting System, QPI.11 Sentinel events.



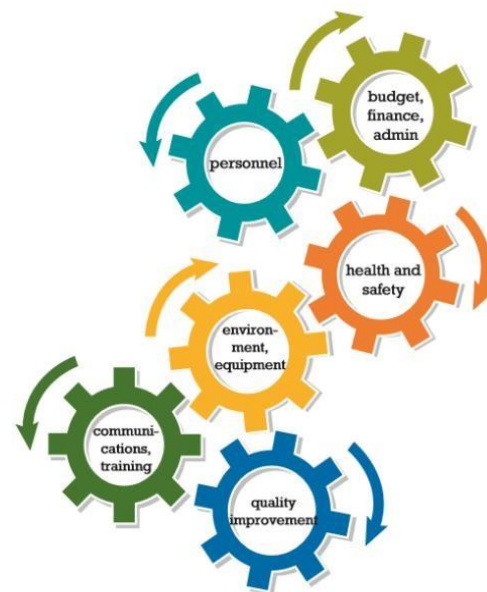
SECTION 3

ORGANIZATION-CENTERED STANDARDS

Section 3: Organization-Centered Standards

In the healthcare sector, the concept of safety often centers around patient care. However, a comprehensive approach to healthcare must also consider the safety and well-being of healthcare professionals. These professionals are integral to the functionality and effectiveness of any healthcare system. Despite ongoing debates about whether worker well-being should be considered part of patient safety initiatives, it is undeniable that the safety and mental health of healthcare workers are crucial. Many healthcare organizations, including leading global institutions, now recognize this and incorporate worker well-being into their safety strategies.

Hospitals are among the most hazardous workplaces, as highlighted by the United States Department of Labor's Occupational Safety and Health Administration (OSHA). Healthcare professionals face a higher risk of non-fatal illnesses and injuries than those in construction and manufacturing. Between 2002 and 2013, the rate of serious workplace violence incidents requiring time off for recuperation was more than four times higher in healthcare than in private industry on average. These figures underscore the critical need for effective safety measures in healthcare settings. While workplace violence and injuries come at a high cost, both financially and emotionally, they are largely preventable through appropriate training, safety protocols, and supportive workplace environments. Beyond physical safety, healthcare professionals also face significant stress. Prolonged exposure to stress can reduce efficiency and negatively impact health, family, and social life. It is important to distinguish between general stress and workplace-specific stress. Healthcare is inherently stressful, with some professions ranking among the most stressful. Not all healthcare workers experience stress at the same level, nor do they all reach the point of professional burnout. Studies indicate that Intensive Care Unit (ICU) staff often report dealing with death as their primary stressor, whereas nurses in internal medicine or surgical departments cite workload and workforce planning as major stress sources. Addressing stress in healthcare settings requires a multifaceted approach, including adequate staffing, appropriate workload distribution, and support systems for healthcare professionals. Hospital structure is a vital component in maintaining both patient and worker safety. A well-defined organizational structure clarifies roles and responsibilities, streamlines workflows, and supports the addition of new positions as needed, facilitating growth and adaptation to changing healthcare demands. Effective hospital management must adhere to a clear ethical framework that responds to community needs and involves staff in community assessments and responses. This engagement ensures that workers feel valued and that their safety and stress concerns are addressed proactively. Both management and staff share responsibility for maintaining a safe workplace. While management is tasked with providing personal protective equipment (PPE) and detailed work instructions, staff must adhere to safety protocols and use the equipment as required. This collaborative approach helps prevent safety failures and promotes a culture of mutual accountability and continuous improvement. To address these challenges and create a safer, more efficient healthcare environment, innovative tools like HealthWISE have been developed. Created by the International Labor Organization (ILO) in collaboration with the World Health Organization (WHO), HealthWISE is a practical, participatory, and cost-effective tool designed to improve work conditions, performance, occupational health and safety, and the quality of healthcare services. By fostering collaboration between management and staff, HealthWISE encourages a culture of continuous improvement and engagement, aiming to make healthcare settings safer and more effective for both workers and patients.



Environmental and Facility Safety

Chapter intent:

Hospitals are complex environments that demand meticulous attention to both environmental and facility management to ensure the safety and well-being of patients, staff, and visitors. Environmental and Facility Safety (EFS) in hospitals is a multifaceted discipline aimed at minimizing risks and creating a safe, secure, and compliant healthcare environment. This involves adherence to local laws, regulations, fire and building codes, and the implementation of best practices in environmental management. The scope of EFS includes everything from waste management and environmental safety to the prevention of accidents and the training of healthcare staff in emergency preparedness and safety procedures.

Facility safety involves the establishment of organized efforts and procedures to identify workplace hazards and reduce the risk of accidents and exposure to harmful situations. This includes maintaining the structural integrity of the hospital building, ensuring compliance with fire and building codes, and conducting regular inspections to identify and address potential hazards. A critical component of facility safety is the development and implementation of emergency preparedness plans, enabling hospitals to respond effectively to a wide range of emergencies, from natural disasters to man-made crises.

Training hospital staff is essential for both environmental and facility safety. Staff members must be thoroughly trained in accident prevention, emergency response, and the use of protective equipment. This training should be ongoing and cover various important topics, such as handling hazardous materials, responding to fires or chemical spills, and safely evacuating patients during emergencies.

Additionally, implementing energy-efficient systems, using sustainable materials, and reducing water consumption are key aspects of a hospital's environmental management strategy. These practices contribute not only to the safety of the hospital environment but also to the broader goal of environmental sustainability.

Chapter Purpose:

This chapter begins by focusing on the planning and effective management of hospital environmental facility safety. It then outlines the need for the development, implementation, monitoring, improvement, evaluation, and annual updating of environmental safety plans. The primary objective is to ensure that the organization can identify safety issues and establish safe, effective plans to maintain and enhance environmental safety. The chapter covers the following key areas:

- **Fire Safety:** strategies for fire prevention, early detection, appropriate response, and safe evacuation in case of a fire.
- **Hazardous Materials:** measures for the safe handling, storage, transportation, use, and disposal of hazardous materials and waste.
- **Safety:** Ensuring a safe work environment for all occupants by maintaining hospital buildings, construction areas, and equipment so they do not pose hazards or risks to patients, staff, and visitors.
- **Security:** Protecting the property of all occupants from loss, theft, destruction, tampering, or unauthorized access or use.
- **Medical Equipment:** Processes for selecting, inspecting, testing, maintaining, and safely using medical equipment.
- **Utility Systems:** Ensuring the efficiency and effectiveness of all utilities through regular inspection, maintenance, testing, and repair to minimize the risk of operational failures.
- **Disaster Preparedness:** Preparing for and responding to disasters and emergencies that may occur within the hospital's geographical area, including evaluating the structural integrity of the patient care environment.

EFS chapter Summary of Changes*Summary of Changes Chapter 9*

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
EFS.01 KW: Hospital environment and facility safety management	EFS.01 KW: Hospital environment and facility safety structure	1) Modified EOC: (EOC.01: The hospital maintains basic requirements for compliance with local laws and regulations and codes with different alternatives). 2) Added new EOCs: • (EOC.03: The non-standalone hospital has evidence of maintenance of shared utilities, systems, and different alternatives according to national laws and regulations). • (EOC.04: The hospital ensures that independent entities comply with all aspects of the facility management plans) • (EOC.05: The hospital budgets for maintaining and upgrading hospital environmental safety.) • (EOC.06: The Hospital leadership ensures that all environmental and facility safety plans are evaluated and updated annually with improvement, when required.)
EFS.02 KW: Environment and facility safety monitoring	EFS.01 KW: Hospital environment and facility safety structure EFS.02 Environment and facility safety program monitoring	• Updated standard (EFS.02) by merging two Standards (EFS.01 & EFS.02) in Hospital edition 2021.
EFS.03	EFS. 03	1)Modified EOCs:

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
KW: Fire and smoke safety	KW: Fire and smoke safety	<ul style="list-style-type: none"> • EOC.01: The hospital has an approved and updated fire and smoke safety plan that includes all elements from a) through f) in the intent. • EOC.03: (The hospital fire alarm, and smoke containment system are available, accessible, functioning and compliant with civil defence requirements.) • EOC.05: (Evacuation path is clearly marked with exit signs and free from obstructions.)
EFS.04 KW: Fire drills	EFS.05 KW: Fire drills	<ol style="list-style-type: none"> 1) Rephrasing of standard statement to be: (Fire drills are performed in different clinical and non-clinical areas). 2) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01 Fire drills are performed at least quarterly, including one unannounced drill annually). • (EOC.03 Fire drill results are recorded including items from a) through d), that are mentioned in the intent. 3) Updated EOC (EOC.04) by merging two EOCs (EOC.04 and EOC.05) in Hospital edition 2021. 4) Added a new EOC: (EOC.05: The hospital staff guarantee safe evacuation path for patients, staff, and visitors).
EFS.05 KW: Smoking-Free Environment	EFS.04 KW: Smoking-Free Environment	Added a new EOC: (EOC.05: The hospital documents penalties and corrective actions for policy violations).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
EFS.06 KW: Hazardous materials safety and waste management	EFS.06 KW: Hazardous materials safety	<p>1) Rephrasing of standard statement to be: (The hospital plans safe handling, storage, usage and transportation of hazardous materials and waste management).</p> <p>2) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved and updated hazardous material and waste management plan that addresses all elements from a) through k) in the intent). <p>3) Added new EOCs:</p> <ul style="list-style-type: none"> • (EOC.02: The hospital ensures availability of the hospital SDS). • (EOC.03: Staff is trained on hazards material and waste management plan). • (EOC.05: The hospital ensures that waste handling, storage, and labeling are according to laws and regulations).
EFS.07 KW: Safety Management Plan	EFS.07 KW: Safety Management Plan	<p>1) Modified EOC: (EOC.01: The hospital has an approved and updated plan to ensure a safe work environment including all elements from a) through h) in the intent)</p> <p>2) Added a new EOC: (EOC.04: PPEs are available and used whenever indicated).</p>
EFS.08	EFS.08	<p>1) Rephrasing of EOC.03: (The hospital performs preventive and corrective actions whenever risks are identified).</p>

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
KW Pre-risk Construction assessment	KW: Pre-Construction risk assessment	2) Added a new EOC: (EOC.04: There is a mechanism, such as work permission, to empower risk assessment and recommendations).
EFS.09 KW: Security plan.	EFS.09 KW: security plan	1) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01 The hospital has an approved updated security plan that includes items a) through k) in the intent.) • (EOC.02: Involved staff members are trained on the plan.) 2) Added a new EOC.06: (Drills for child abduction are conducted at least biannually).
EFS.10 KW: Medical Equipment Plan	EFS.10 KW: Medical Equipment Plan	1) Modified EOC.01: (The hospital has an approved and updated medical equipment management plan that addresses all elements from a) through c) in the intent). 2) Added a new EOC: (EOC.06: Equipment adverse incidents are reported, and actions are taken).
EFS.11 KW: Utilities Management.	EFS.11 KW: Utilities Management	1. Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved and updated plan for utility management that includes items a) through l) in the intent). • (EOC.02: The hospital has a trained staff members to oversee utility management) 2. Added a new EOC: (EOC.03: The hospital utility management plan is implemented).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
EFS.12 KW: Water services	EFS.12 KW: Water services	<p>1) Modified standard statement: (Water services are managed according to laws and regulations).</p> <p>2) Rephrased EOC: (EOC.03: Regular chemical and microbiological analyses are performed and recorded for water services and dialysis water).</p>
EFS.13 KW: Disaster Plan	EFS.13 KW: Disaster Plan	<p>1) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.01: The hospital has an updated and approved hospital emergency preparedness plan that includes items a) through i) in the intent. • (EOC.02: Staff members are trained on the plan). • (EOC.03: The hospital performs at least one drill biannually, including items from I) to V) in the intent).
EFS.14 KW: Environmental Sustainability, Green Healthcare		New standard

Effective leadership and planning of environment and facility safety.

EFS.01 Hospital facilities comply with laws, regulations, fire, and national building codes.

Safety

Keywords:

Hospital environment and facility safety management

Intent:

Building codes were established to provide guidance on safety measures while designing hospital settings. The hospital should comply with relevant laws, regulations, and codes, such as civil defense, fire, and building codes, to ensure the safety of patients, staff, visitors, vendors, and the environment.

While hospitals are meant to provide healing and comfort, they also include certain dangers. Hospitals contain hazardous chemicals, chemotherapeutic drugs, radioactive material, and infectious matter, among other threatening items. In addition, there are also dangers from fire and smoke that can be particularly perilous for vulnerable hospital patients, staff, visitors, and vendors. Safe evacuation and traffic inside the facility are directly related to the design and code compliance as regards the number of 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 hospitals, 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.
- Hospitals that were designed and built before the application of some codes or laws and regulations to re-adjust their current situation according to basic alternatives to keep safety for all.
- When the organization has nonhospital 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 defense and other local authorities, reports an observation during the inspection, the hospital leadership is responsible for providing a corrective action plan and following up on any non-compliance within the required timeframe.

The hospital should have a current permit, licenses, and design drawings, as well as budget availability for upgrading and/or replacing instruments or systems to maintain environmental safety and/or expand the services provided.

Survey process guide:

- GAHAR surveyor may review documents demonstrating hospital drawings, budget, and external authorities reports with action plans.
- GAHAR surveyor may observe to ensure compliance with local laws and regulations requirements and matching allocated spaces to departmental functions.
- GAHAR surveyor may review all the environmental and facility safety plans to ensure they are all evaluated and updated.

Evidence of compliance:

1. The hospital maintains basic requirements for compliance with local laws, regulations, and codes with different alternatives.

2. The hospital's leadership ensures compliance with external inspection reports and correction of observations within the required timeframe.
3. The non-standalone hospital has evidence of maintenance of shared utilities, systems, and different alternatives according to national laws and regulations.
4. The hospital ensures that independent entities comply with all aspects of the facility management plans.
5. The hospital budgets for maintaining and upgrading hospital environmental safety.
6. The hospital leadership ensures that all environmental and facility safety plans are evaluated and updated annually, with improvements when necessary.

Related standards:

EFS.03 Fire and smoke safety, EFS.13 Disaster Plan, EFS.04 Fire drills, EFS.07 Safety Management Plan, DAS.01 Planning medical imaging services, DAS.10 Laboratory services planning and management, DAS.09 Radiation Safety Program, DAS.23 Laboratory Safety Program

EFS.02 Hospital environment and facility safety are overseen and monitored by qualified staff.

Safety

Keywords:

Environment and facility safety monitoring

Intent:

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

The hospital should ensure the availability of qualified and trained staff (at least training on safety requirements and civil defense) according to the scope of the provided services, local laws, and regulations.

The hospital should have a committee overseeing environmental safety activities with defined terms of reference. The committee's role includes reviewing aggregated essential data, incident reports, drill reports, safety plan measures, recommended actions, and following up to ensure compliance with all safety requirements. The committee should report to the hospital's leadership quarterly, and feedback from hospital leadership should be received.

One or more qualified individuals is/are responsible for inspecting buildings to identify maintenance and safety issues, such as clogged drains, leaky ceilings, and faulty electrical switches. Different tools could be used, like inspection checklists that cover different components of environmental safety activities. Risk assessment is used to identify high-risk observations that require appropriate intervention.

The hospital should create continuous monitoring mechanisms for environmental and facility safety. A multidisciplinary environment and facility surveillance team is formed from all stakeholders, e.g. (safety officer, utility responsible person, biomedical, quality professional, infection control, and others as appropriate). The team shall perform surveillance rounds across all hospital areas and services, including independent entities, at least quarterly. Environment and facility surveillance round reports should be sent to the concerned stakeholders, environment and facility safety committee, and hospital leadership.

Survey process guide:

- GAHAR surveyor may review documents demonstrating environmental and facility surveillance plans, surveillance schedules, rounds, and reports.
- GAHAR surveyor may review the environment and facility safety committee meeting agenda, meeting minutes, and meeting notes to ensure round report observations are considered during meetings.
- 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 hospital ensures the availability of environmentally safe, qualified staff who match the needs of the hospital's scope of services, laws, and regulations.
2. The hospital has a committee overseeing environmental safety activities with defined membership and terms of reference.
3. The committee meets on a regular basis, and the minutes of meetings are recorded.
4. The hospital ensures that multidisciplinary environmental and facility surveillance rounds are performed at least quarterly across all hospital areas and services, including independent entities.
5. A report is submitted quarterly to the hospital's governing body about the significant observations during the surveillance rounds and the corrective actions taken or needed.

Related standards:

OGM.05 Committee structure, OGM.04 Hospital Director, OGM.08 Hospital leaders, OGM.09 Departmental management, OGM.03 Effective communication with the governing body

Safe fire planning

EFS.03 GSR.23 Fire and smoke safety plan addresses prevention, early detection, response, and safe evacuation in case of fire and/or other internal emergencies.

Safety

Keywords:

Fire and smoke safety

Intent:

One critical consideration for the hospitals' safety design is the prevention of fire, particularly with respect to the combustibility of construction and furnishing materials and the spread of fire and smoke.

Fire alarm systems and suppression equipment need to be readily accessible to combat accidental or malicious fires. Hospital staff must be knowledgeable about equipment usage, remain calm, and communicate effectively based on previous arrangements and training.

If all attempts to fully suppress the fire fail, the hospital evacuates. The main goal of hospital evacuation is moving all patients, visitors, and staff out of dangerous and/or damaged areas as safely as possible. Priorities and respect should be taken into consideration during hospital evacuation. Independent cases then dependent cases using simple and available tools like mattresses, bed sheets, trolleys, wheelchairs, or other tools.

Proactive periodical environmental safety risk assessments for hospitals should be performed, with required risk mitigation measures for different hospital areas.

During an evacuation scenario, paying attention to detail and processes will not be optimal. Understanding key principles is sufficient for helping staff members make good decisions during a chaotic event.

The hospital shall develop and implement a fire, smoke, and non-fire safety plan based on environmental safety risk assessment that addresses at least the following:

- a) Preventive measures:
 - Safe storage and handling of highly flammable materials.
 - Assesses compliance with Civil Defence requirements or recommendations.
 - Fire and smoke separation, areas under construction, and other high-risk areas, such as stores, fuel tanks, kitchens including hoods, generators, laundry, oxygen supply, medical gases rooms, electrical control panels, medical records room, garbage room, etc., with risk mitigation measures.
- b) Fire alarm and smoke detection system, including the central control panel connected to all areas in hospitals according to its functionality, and ensure continuous monitoring 24/7.
- c) Fire suppression systems, such as water systems and automated or manual fire extinguishers, and their distribution in the hospital. There should be signs explaining how to activate the fire alarm and use a fire extinguisher and hose reel.
- d) Safe evacuation through a continuous and unobstructed path of travel from any occupied part of the building to a safe area outside the building (assembly areas). This path must be clearly marked with exit signs and free from obstructions.
- e) An annual training plan for all staff, ensuring everyone can proficiently demonstrate RACE, PASS, and other activities that ensure the safety of everyone during fire and non-fire emergencies, with documentation of all results regularly according to the training plan.
- f) The fire and smoke safety plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the fire safety plan and related documents, such as facility fire safety inspections, fire system maintenance, and staff training (all staff should be trained on fire safety).
- GAHAR surveyors may observe to check the availability, accessibility, and effectiveness of fire alarm, firefighting, and smoke containment systems and compliance with civil defense requirements.
- GAHAR surveyor may review the plan of testing (drills).

Evidence of compliance:

1. The hospital has an approved and updated fire and smoke safety plan that includes all elements from a) through f) in the intent.
2. The hospital provides training on fire safety and evacuation for all staff at least annually.
3. The hospital fire alarm and smoke containment system is available, accessible and functioning.
4. The hospital fire firefighting systems are available, accessible and functioning.
5. Inspection, maintenance and testing of fire alarms, firefighting, and smoke containment systems are performed and recorded.
6. The evacuation path is clearly marked with exit signs and free from obstructions.

Related standards:

EFS.01 Hospital environment and facility safety management, EFS.04 Fire drills, EFS.05 Smoking-Free Environment, EFS.07 Safety Management Plan, EFS.13 Disaster Plan, QPI.9 Risk Management Program, WFM.07 Orientation Program, WFM.08 Continuous Education Program

EFS.04 GSR.24 Fire drills are performed in different clinical and non-clinical areas.

Safety

Keywords:

Fire drills

Intent:

A fire drill is designed to ensure staff readiness in case of fire and/or other internal emergencies. It provides staff members with the necessary knowledge and comprehension of the fire safety plan by consistently conducting training sessions and simulations to respond promptly, safely, and appropriately. Periodical drills make the staff self-confident and able to fulfill their responsibilities in the event of a fire. Fire drills in hospitals should be performed at least quarterly, including one unannounced drill annually, and the hospital should record the details of the drill, including, but not limited to, the following:

- a) Dates and timings.
- b) Staff who participated in the drill.
- c) Involved areas.
- d) Shifts.

Survey process guide:

- GAHAR surveyor may review fire and evacuation drill records, including dates, timings, participating staff, and the hospital's involved areas.
- GAHAR surveyor may review the hospital's corrective action plan, which is based on the drill evaluation.
- GAHAR surveyor may interview staff members to check their awareness of the fire safety plan and basic procedures in such cases as 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 annually.
2. All staff members participate in fire drills at least once annually.
3. Fire drill results are recorded, including items from a) through d) that are mentioned in the intent.
4. Fire drill evaluation is performed after performing each drill with a corrective action plan when indicated.
5. The hospital staff guarantees a safe evacuation for patients, staff, and visitors.

Related standards:

EFS.01 Hospital environment and facility safety management, EFS.03 Fire and smoke safety, EFS.13 Disaster Plan, WFM.08 Continuous Education Program

EFS.05 The hospital's clinical and non-clinical areas are smoking-free.

Safety

Keywords:

Smoking-Free Environment

Intent:

According to the Centers for Disease Control (CDC), smoking is responsible for approximately 90% of all lung cancer deaths. Cigarette smoking is responsible for approximately 80% of deaths from chronic

obstructive pulmonary disease (COPD). It also increases the risk of death from all causes in both men and women.

Despite restrictions on smoking inside hospitals, many individuals continue to smoke outside, leading to issues with second-hand smoke exposure, littering, fire hazards, and setting a negative example for others.

Enforcing smoke-free policies is an integral part of a holistic approach to decreasing tobacco use and its associated health risks. Furthermore, implementing anti-smoking regulations has been linked to improvements in employee performance, productivity, and job retention.

The hospital ensures a smoking-free environment for patients through the availability of a smoking-free environment policy and procedure and proper signage according to laws and regulations. The policy should include any exceptions, penalties, and the designated smoking area outside the building. All staff should be aware of the smoking-free environment policy.

Survey process guide:

- GAHAR surveyor may review the hospital's smoking-free policy, followed by interviewing staff members and/or patients to check their awareness of hospital policy.
- GAHAR surveyor may observe the locations of the designated smoking areas.
- GAHAR surveyor may observe to check the presence of cigarette remnants, cigarette packs, and any other evidence of non-compliance with the hospital's policy, especially in remote areas.
- GAHAR surveyor may observe and review to ensure appropriate consequences and action taken in case of non-compliance with the hospital's policy.

Evidence of compliance:

1. The hospital has an approved smoking-free policy.
2. The hospital's staff members, patients, and visitors are aware of the hospital policy.
3. Occupants, according to laws and regulations, do not smoke in all areas except designated areas.
4. The hospital monitors compliance with the smoking-free policy.
5. The hospital documents penalties and corrective actions for policy violations.

Related standards:

EFS.03 Fire and smoke safety, EFS.07 Safety Management Plan, EFS.01 Hospital environment and facility safety management, QPI.9 Risk Management Program

Safe hazardous materials and waste management plan

EFS.06 GSR.25 The hospital plans safe handling, storage, usage, and transportation of hazardous materials and waste management.

Safety

Keywords:

Hazardous materials safety and waste management

Intent:

Hazardous materials are substances that, if released or misused, can threaten the environment, life, or health. These chemicals are used in industry, agriculture, medicine, research, and consumer goods.

Hazardous materials come in the form of explosives, flammable and combustible substances, poisons, and radioactive materials. These substances are most often released because of transportation accidents or chemical accidents in hospitals. As the effects of hazardous materials can be extensive and

catastrophic, it is crucial for hospitals to carefully plan and create a safe working environment for the use of such materials.

Hospital waste refers to any waste produced during the diagnosis, treatment, or immunization of humans or in research within a hospital facility.

According to the World Health Organization (WHO) classification, hospital waste is categorized into the following categories:

- Infectious
- Pathological and anatomical
- Pharmaceutical
- Chemical
- Heavy metals
- Pressurized containers
- Sharps
- Genotoxic/cytotoxic
- Radioactive

These items/ categories can be pathogenic and adversely affect the hospital environment.

Other non-hazardous waste items generated in hospitals as a result of healthcare service provision include medication boxes, packaging for medical items and food, leftover food, and office waste.

To ensure the safety of staff, patients, relatives, vendors, and the environment, it is crucial for the hospital to identify and manage hazardous materials and waste present throughout its premises. This involves using techniques to properly handle and dispose of waste produced by hospitals in order to prevent the spread of diseases.

The hospital shall develop and implement a hazardous material and waste management plan that includes, but is not limited to, the following:

- a) A current and updated inventory of hazardous materials used in the hospital; the inventory should include the material name, hazard type, location, usage, consumption rate, and responsibility.
- b) A safety data sheet (SDS) should be available and include 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 labeling of hazardous materials.
- d) Procedure for safe usage, handling, and storage of hazardous materials.
- e) Appropriate segregation, labeling, handling, storage, transportation, and disposal of all categories of hazardous waste.
- f) Availability of required protective equipment and spill kits.
- g) Investigation and documentation of different incidents, such as spills and exposure.
- h) Compliance with local laws and regulations.
- i) Availability of required licenses and/or permits.
- j) Staff training and orientation.
- k) The plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the hospital's hazardous materials and waste management plan to ensure that it covers all safety requirements for hazardous materials, safe storage, handling, spills, required protective equipment, and waste disposal according to local laws and regulations.
- GAHAR surveyor may review hazardous material, waste inventories, and Safety Data Sheets (SDS).

- GAHAR surveyor may observe to check hazardous material labeling and storage in addition to waste collection segregation storage and final disposal.

Evidence of compliance:

1. The hospital has an approved and updated hazardous material and waste management plan that addresses all elements from a) through k) in the intent.
2. The hospital ensures the availability of the hospital SDS.
3. Staff is trained on hazardous material and waste management plans.
4. The hospital ensures the safe use, handling, storage, and labeling of hazardous materials.
5. The hospital ensures that waste handling, storage, and labeling are according to laws and regulations.
6. The hospital has an approved document for spill management, Investigation, and recording of different incidents related to hazardous materials.

Related standards:

EFS.01 Hospital environment and facility safety management, EFS.07 Safety Management Plan, DAS.09 Radiation Safety Program, DAS.23 Laboratory Safety Program, WFM.07 Orientation Program, WFM.08 Continuous Education Program, IPC.05 PPE guidelines, Physical Barriers

Safety and security planning

EFS.07 GSR.26 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 patients, staff, and visitors. Hospital safety arrangements keep patients, staff, and visitors safe from inappropriate risks such as electricity and inappropriate behavior such as violence and aggression.

The hospital shall develop and implement a safety plan to cover the building, property, medical equipment, and systems to ensure a safe physical environment for patients, families, staff, visitors, and vendors. The safety plan shall include at least the following:

- a) Proactive risk assessment.
- b) Safety measures are based on risk assessment, such as exposure to infectious agents, electric and radioactive hazards, vibration, and noise.
- c) Identify potential risks because of system failure and/or staff behavior (for example, wet floor; water leakage from the ceiling beside electrical compartments; improper handling of sharps; non-compliance to personal protective equipment in case of working at heights, cutting, and welding, dealing with high voltage; and unsafe storage).
- d) Processes for pest and rodent control.
- e) Regular inspection with documentation of results, performing corrective actions, and appropriate follow-up.
- f) Responsibilities according to laws and regulations.
- g) Safety training depending on job hazard analysis.
- h) The plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the hospital safety plan to ensure that suitable risk assessment is included.
- GAHAR surveyor may review 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 observe to check availability and ensure staff compliance with suitable personal protective equipment (PPE) in different areas like workshops and waste collection areas.

Evidence of compliance:

1. The hospital has an approved and updated plan to ensure a safe work environment, including all elements from a) through h) in the intent.
2. Safety instructions are posted in all high-risk areas.
3. Staff are aware of safety measures based on their job hazards.
4. PPEs are available and used whenever indicated.
5. Safety measures are implemented in all areas.

Related standards:

EFS.01 Hospital environment and facility safety management , DAS.09 Radiation Safety Program, DAS.23 Laboratory Safety Program, EFS.03 Fire and smoke safety , EFS.06 Hazardous materials safety and waste management, QPI.9 Risk Management Program, WFM.07 Orientation Program , WFM.08 Continuous Education Program, IPC.05 PPE guidelines, Physical Barriers, EFS.08 Pre-Construction risk assessment

EFS.08 The hospital performs a pre-construction risk assessment when planning for construction or renovation.

Safety

Keywords:

Pre-Construction risk assessment

Intent:

The new construction or renovation of a hospital has detrimental effects on all occupants, including changes in air quality due to dust or odors, increased noise and vibration, and potential hazards from debris.

Upon new construction or renovation in the hospital, a pre-construction risk assessment (PCRA) should be performed and evaluated to develop a plan that will minimize associated risks. 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, should be ensured.

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 hospital shall ensure monitoring and documentation of all activities, and all risks related to construction and renovation.

Survey process guide:

- GAHAR surveyor may review the hospital pre-construction risk assessment documents.
- GAHAR surveyor may observe the implemented risk assessment recommendations.
- GAHAR surveyor may interview staff, patients, or contractors in the construction area to check their awareness of required precautions.

Evidence of compliance:

1. The hospital performs a pre-construction risk assessment before any construction or renovation.
2. All affected departments are involved in the risk assessment.
3. The hospital performs preventive and corrective actions whenever risks are identified.
4. There is a mechanism, such as work permission, to empower risk assessment and recommendations.
5. If a contractor is used, contractors' compliance is monitored and evaluated by the hospital.

Related standards:

EFS.03 Fire and smoke safety, EFS.06 Hazardous materials safety and waste management, EFS.07 Safety Management Plan, QPI.9 Risk Management Program , IPC.02 IPC program, risk assessment, guidelines

EFS.09 Security plan addresses the security of all occupants and properties, including restricted and isolated areas, with risk mitigation, control measures, tools, and responsibilities.

Safety

Keywords:

Security Plan

Intent:

Hospitals frequently experience security concerns such as violence, aggression, theft, harassment, suicide, bomb threats, terrorism, gun violence, and child abductions.

Usually, hospitals enforce a code of behaviour in place that prohibits any form of physical or verbal aggression or abuse towards staff, patients, family members, or visitors.

In order to ensure the safety of staff, patients, and visitors, hospitals may implement various security measures such as closed-circuit television (CCTV) cameras, duress alarms for staff members, and electronic access control systems for doorways.

Security staff are also employed by some hospitals to ensure the safety and protection of all individuals from various potential threats, such as violence, theft, harassment, suicide, Medical Records, bomb threats, terrorism, gun violence, and child abduction.

The hospital shall develop and implement a security plan that includes at least the following:

- a) Security risk assessment.

- b) Ensuring the identification of inpatients and staff in the hospital.
- c) Ensuring the identification of visitors and vendors/contractors with restrictions on their movement within the hospital.
- d) Identification of restricted areas.
- e) Vulnerable patients such as the elderly, infants, those with mental disorders, and handicapped should be protected from abuse and the above-mentioned harms.
- f) Children should be protected from abduction.
- g) Drill for child abduction should be performed at least biannually.
- h) monitoring of remote and isolated areas.
- i) Workplace violence management.
- j) Staff training and orientation.
- k) The plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the hospital security plan/s to ensure that they include appropriate risk assessment, surveillance, security measures for high-risk areas, and access control areas.
- GAHAR surveyor may review the surveillance rounds plan, checklist, different observations, and proper corrective actions, if applicable.
- GAHAR surveyor may observe the implemented security measures, e.g., cameras, monitors, staff ID, and access-controlled areas.

Evidence of compliance:

1. The hospital has an approved updated security plan that includes items a) through k) in the intent.
2. Involved staff members are trained on the plan.
3. The hospital ensures the identification of occupants.
4. Security measures are implemented.
5. Restricted and isolated areas are protected and secured.
6. Drills for child abduction are conducted at least biannually.

Related standards:

EFS.13 Disaster Plan, PCC.02 Patient and family rights, PCC.14 Patient's belongings, QPI.9 Risk Management Program, WFM.07 Orientation Program, WFM.08 Continuous Education Program

Safe medical equipment

EFS.10 GSR.27 Medical equipment plan ensures selection, inspection, testing, maintenance, and safe use of medical equipment.

Safety

Keywords:

Medical Equipment Plan

Intent:

The management of medical equipment is crucial for the accurate diagnosis and effective treatment of patients. Within hospitals, a trained team of biomedical engineers oversees the entire medical equipment inventory and assumes responsibility for addressing and dealing with hazards associated with this equipment.

Managing such a large number of equipment can be challenging, especially when the stakes are so high. Neglecting proper monitoring and management not only results in inefficiency but also poses a serious risk to patient outcomes. For instance, neglecting maintenance raises the likelihood of equipment downtime, and inadequate servicing can have detrimental effects on both medical professionals and patients. This emphasizes the importance of implementing safety and service guidelines for medical equipment.

The hospital shall develop and implement a plan for medical equipment management that contains at least the following:

- a) Selection, inspection, and testing of medical equipment:
 - i. Developing criteria for selecting new medical equipment.
 - ii. Inspection and testing of new medical equipment upon procurement and on a predefined interval basis.
 - iii. 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.
 - iv. Inventory of medical equipment, including availability and functionality.
 - v. Identification of critical medical equipment that should be available for the operator even through the provision of backup such as life-saving equipment, ventilator, and DC shock.
- b) Maintenance and safe use of medical equipment:
 - I. 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 labeling malfunctioned equipment.
 - II. Calibration of medical equipment according to the manufacturer's recommendations and/or its usage.
 - III. Malfunction and repair of medical equipment.
 - IV. Dealing with adverse incidents involving equipment, including actions taken, backup system, and reporting.
 - V. Updating, retiring, and/or replacing medical equipment in a planned and systematic way.
- c) The plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the hospital medical equipment management plan and related documents, e.g. (inventory of medical equipment, preventive maintenance schedule, calibration schedule, and staff training records).
- GAHAR surveyor may observe the medical equipment functionality.

Evidence of compliance:

1. The hospital has an approved and updated medical equipment management plan that addresses all elements from a) through c) in the intent.
2. The hospital has a qualified individual to oversee medical equipment management.
3. The hospital 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:

DAS.18 Laboratory Internal quality assessment, DAS.19 Laboratory external quality assessment , DAS.24 Point of care testing , OGM.10 Supply Chain Management , DAS.05 Medical imaging quality assurance and control , WFM.08 Continuous Education Program, CSS.02 Critical alarms

Safe utility plan

EFS.11 GSR.28 Essential utility plan addresses regular inspection, maintenance, testing, and repair.

Safety

Keywords:

Utility Management

Intent:

As hospital's utility systems form the operational infrastructure that enables the provision of safe patient care, it is crucial for hospitals to plan and implement effective response and recovery activities in the event of a failure in their utility systems.

Some of the essential utilities include mechanical systems (e.g., heating, ventilation, and cooling); electrical systems (e.g., normal power and emergency power); domestic hot and cold water as well as other plumbing systems; waste; technology systems, including the myriad communications and data transfer systems; vertical transportation systems; fuel systems; access control, duress alarm, and surveillance systems; medical gases, air and vacuum systems; and pneumatic tube systems.

The hospital shall have a utility management plan to ensure the efficiency and effectiveness of all utilities.

The plan shall include at least the following:

- a) Inventory of all essential utility 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 systems.
- 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 for chemical and bacteriological examination with documentation of the results at least quarterly and/or more frequently if required by local laws and regulations or conditions of the source of water.
- i) Preventive maintenance plan, according to the manufacturer's recommendations.
- j) Identification of critical utility systems and ensuring backup availability.
- k) The hospital performs regular, accurate data aggregation and analysis (for example, frequency of failure, preventive maintenance, compliance with proper monitoring, updating, and improvement of the different systems).
- l) The plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the hospital utility management plan to ensure coverage of all required measures, e.g., regular inspection, maintenance, and backup for all essential utility systems management.
- GAHAR surveyor may review inspection records, preventive maintenance schedule, contracts, as well as testing results of generators, tanks, and/or other essential utility systems to make sure of facility coverage 24/7.

Evidence of compliance:

1. The hospital has an approved and updated plan for utility management that includes items a) through l) in the intent.
2. The hospital has trained staff members to oversee utility management.
3. The hospital utility management plan is implemented.
4. Records are maintained for utility systems inventory, testing, periodic preventive maintenance, and malfunction history.
5. Critical utility systems are identified, and backup availability is ensured.

Related standards:

EFS.07 Safety Management Plan, WFM.08 Continuous Education Program, EFS.12 Water services

EFS.12 Water services are managed according to laws and regulations.

Safety

Keywords:

Water services

Intent:

Water delivery systems are essential components of the environment of care in hospitals that must be continually maintained safely.

Failure to deliver safe water will increase infection risk either directly through unsafe water consumption or use or indirectly due to the inability of healthcare professionals to comply with basic infection control measures such as hand hygiene.

Using water of appropriate quality in the preparation of dialysis fluid is crucial for hemodialysis and related therapies to safeguard patients from potential adverse effects caused by known chemical and microbiological impurities found in water and improperly prepared dialysis fluid.

The maintenance of water quality standards by the community's public water supplier, often a municipality in the hospital's area, is essential for guaranteeing safe water services.

Once the water enters the facility's distribution infrastructure, the responsibility for maintaining water quality shifts to the facility. This reflects a collaborative effort and complementary roles in infection prevention (refer to the WHO wash program).

The hospital shall develop and implement a policy and procedures guiding the management of safe water services.

The policy shall address 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 hospital policy guiding the safe water services management.
- GAHAR surveyor may interview staff members to check their awareness of the hospital 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 review corrective actions taken by the hospital and assess their implementation measures.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through e).
2. The hospital has a continuous water supply.
3. Regular chemical and microbiological analyses are performed and recorded for water services and dialysis water.
4. The hospital conducts appropriate corrective actions when needed.

Related standards:

EFS.11 Utility Management

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 hospital.

Safety

Keywords:

Disaster Plan

Intent:

With climate changes, increased pollution, and technological advancements, Earth is becoming vulnerable to natural disasters. Floods, droughts, cyclones, earthquakes, and landslides are common. The last few decades have witnessed an increase in the 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 hospital should have a risk assessment tool to prioritize potential emergencies based on probability and impact.

The hospital shall develop and implement an emergency preparedness plan that includes at least the following:

- a) 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.
- b) Risk assessment of potential epidemics and/or pandemics.
- c) Degree of preparedness according to the level of risk.
- d) Communication strategies: Internal communication may take the form of a clear call tree that includes staff titles and contact numbers, and external communication channels may include civil defense, ambulance centers, and police.
- e) Clear duties and responsibilities for hospital leaders and staff.

- f) Identification of required resources such as utilities, medical equipment, medical, and nonmedical supplies, including alternative resources.
- g) Business Continuity:
 - i. Triageing.
 - ii. Staff's main task is maintained in case of emergencies: management of clinical activities during a disaster, such as operating theatre and intensive care units.
 - iii. Alternative care sites and backup utilities.
 - iv. Safe patient transportation in case of emergency is arranged by the hospital.
- h) Drill schedule: The hospital must schedule a drill for emergencies at least bi-annually and ensure staff attendance. Proper evaluation and recording of the drill include, but are not limited to:
 - I. Scenario of the drill
 - II. Observations on code announcement, timing, staff attendance, response, communication, triaging, and clinical management.
 - III. Clear corrective actions if needed.
 - IV. Feedback to the environmental safety committee.
 - V. Debriefing.
- i) The plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the emergency preparedness plan and related records to ensure coverage of all identified risks.
- GAHAR surveyor may interview staff members to check their awareness of the hospital policy and review training documents.
- GAHAR surveyor may trace to ensure the availability of all needed equipment, medications, supplies, action cards, and others.

Evidence of compliance:

1. The hospital has an updated and approved hospital emergency preparedness plan that includes items a) through i) in the intent.
2. Staff members are trained on the plan.
3. The hospital performs at least one drill biannually, including items from I) to V) in the intent.
4. The hospital demonstrates preparedness for identified emergencies.

Related standards:

EFS.03 Fire and smoke safety, EFS.07 Safety Management Plan, EFS.04 Fire drills, QPI.9 Risk Management Program, WFM.08 Continuous Education Program, WFM.07 Orientation Program

EFS.14: The hospital leadership supports green and sustainable activities.

Keywords:

Environmental Sustainability, Green Healthcare

Intent:

As energy deficiencies and environmental concerns escalate, adopting green practices in healthcare is no longer optional; it's essential. Sustainable solutions offer a win-win-win: Triple Win for Health, Earth Planet, and Budgets.

Hospitals strive to minimize their environmental impact while delivering quality care. The hospital leaders have to integrate environmental strategies into operations and governance, employee engagement, and resource reduction. The hospital shall develop and implement a policy and procedures guiding environmental sustainability activities; the policy includes at least the following:

- a) Leadership Commitment: Leaders demonstrate commitment to environmental sustainability by including it in policies.
- b) Employee Engagement: including activities to raise awareness, train staff on climate change and environmental practices, and encourage participation in eco-friendly initiatives.
- c) Waste Management: establish a comprehensive waste management system that prioritizes waste reduction and proper segregation.
- d) Green Infrastructure: considers opportunities for green infrastructure solutions through:
 - i. Prioritizing natural lighting and avoid unnecessary outside lighting,
 - ii. Efficient energy use through using LED bulbs, lighting with motion sensors, using an air conditioning system (24°C), and after-working hours' equipment shutdowns if applicable.
 - iii. Water-saving fixtures further enhance sustainability.
- e) 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 hospital policy guiding environmental sustainability activities.
- GAHAR surveyor may assess 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 hospital has an approved policy that addresses all elements from (a) to (e) in the intent.
2. Leadership participates in environmental sustainability activities.
3. Staff is aware of environmental sustainability practices.
4. The hospital demonstrates green infrastructure solutions to reduce the use of energy and water.

Related standards:

WFM.08 Continuous Education Program, EFS.02 Environment and facility safety monitoring , OGM.08 Hospital leaders,EFS.06 Hazardous materials safety and waste management

Infection Prevention and Control

Chapter intent:

Hospitalized patients often have compromised immune systems due to underlying medical conditions or invasive procedures, making them more vulnerable to infections. Without stringent infection control measures in place, these individuals are at an increased risk of acquiring various pathogens during their hospital stay.

Infection prevention and control standards are crucial for maintaining a safe healthcare environment. By setting and adhering to these standards, healthcare facilities can effectively minimize the risk of healthcare-associated infections and safeguard the well-being of patients, staff, and visitors.

These standards outline best practices for preventing the spread of infectious diseases, including the adoption and implementation of evidence-based hand hygiene guidelines, proper use of personal protective equipment, environmental cleaning and disinfection, isolation procedures and more.

By consistently following these established standards, hospitals can create a culture of infection prevention that prioritizes patient safety and supports the delivery of high-quality care.

First and foremost, infection prevention and control programs in hospitals are essential for safeguarding patient safety.

By implementing robust infection prevention programs, hospitals can significantly reduce the likelihood of patients developing secondary infections that could prolong their hospitalization or lead to severe complications.

The importance of this program cannot be overstated, as it plays a vital role in maintaining a safe environment for all individuals involved in the healthcare system.

Standard precautions, including hand hygiene, use of personal protective equipment, safe handling of patient care equipment, environmental cleaning and disinfection and respiratory hygiene, are fundamental components in preventing the spread of infections.

Transmission-based precautions should also be implemented when caring for patients with known or suspected infectious diseases that require additional precautions beyond standard precautions.

An aseptic technique should also be employed when performing invasive procedures or handling sterile items.

Infection prevention and control bundles are essential in healthcare settings to effectively reduce the risk of healthcare-associated infections. These bundles typically consist of a set of evidence-based practices that, when implemented together, can significantly improve infection prevention efforts. By incorporating components such as hand hygiene protocols, environmental cleaning standards, proper use of personal protective equipment, and surveillance for infectious diseases, healthcare facilities can create a comprehensive approach to controlling and preventing the spread of infections. Implementing these bundles not only ensures consistency in infection control practices but also helps streamline processes for staff members, ultimately leading to improved patient safety and reduce healthcare-associated infections.

Overall, investment in robust infection prevention and control programs is critical for hospitals aiming to prioritize patient safety while upholding high standards of care delivery. These efforts not only demonstrate a commitment towards mitigating avoidable harm but also underscore an institution's dedication towards promoting a safe environment that benefits everyone within its care ecosystem.

Chapter purpose:

- a) To ensure efficient structure of the infection prevention and control program.
- b) To ensure safe standard precautions.
- c) To ensure safe transmission-based precautions for immunocompromised hosts.
- d) To ensure safe laundry and healthcare textile management.
- e) To ensure effective epidemiological surveillance and monitoring.

IPC chapter Summary of Changes

Summary of Changes Chapter 10

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
IPC.01 KW: Infection prevention and control (IPC) Team, certification, qualification and training	IPC.01 KW: Infection prevention and control (IPC) Team, certification, IPC qualification and training	1) Rephrasing of EOC: (EOC.03: The IPC team members are qualified and trained).
IPC.02 KW: IPC program, risk assessment, guidelines	IPC.02 KW: IPC program, risk assessment, guidelines	1) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has an infection control program that addresses all the elements mentioned in the intent from a) through i). • (EOC.04: The program is implemented in all hospital areas and covers patients, visitors, and staff). 2) Updated EOC.05 by merging two EOCs (EOC.05: and EOC.06) in Hospital edition 2021.
IPC.03 KW: IPC committee, meetings	IPC.03 KW: IPC committee, meetings	1) Modified EOC: (EOC.01: There are clear terms of reference for the infection control committee that includes at least from a) to g) in the intent). 2) Rephrasing of EOC: (EOC.04 The committee minutes are recorded).
IPC.04 KW: Hand Hygiene	IPC.05 KW: Hand Hygiene	1) Modified EOC: (EOC.01: The hospital has approved Hand Hygiene policies and procedures based on current professional guidelines that address all the elements mentioned in the intent from a) to g).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<p>2) Added a new EOC: (EOC.03: Hand hygiene is implemented according to the policy).</p> <p>3) Updated (EOC.06) by merging two EOCs (EOC.04 and EOC.05) in Hospital edition 2021</p>
IPC.05 KW: PPE, guidelines, Physical Barriers	IPC.06 KW: PPE, guidelines, Physical Barriers	<p>5) Added a new EOC: (EOC.04: Hospital staff is trained on the proper way and sequence of donning and doffing of various PPE).</p> <p>6) Modified EOC: (EOC.01: The hospital has a personal protective equipment policy that includes items mentioned in the intent from a) through e).</p>
IPC.06 KW: detergents, antiseptics, and disinfectants	IPC.07 KW: detergents, antiseptics, and disinfectants	1) Modified standard statement: (Detergents, antiseptics, and disinfectants are available, selected and used according to current national/international guidelines).
IPC.07 KW Respiratory Hygiene Protocol, cough etiquette	IPC.08 KW: Respiratory Hygiene Protocol, cough etiquette	1) Modified EOC: (EOC.01: Respiratory hygiene/cough etiquette supplies are displayed at appropriate places).
IPC.08 KW: Safe injection practices	IPC.09 KW: Safe injection practices	<p>1) Rephrasing of standard statement to be: (The hospital ensures Safe injection practices).</p> <p>2) Rephrased EOC: (EOC.03: The hospital ensures single use of the fluid's infusion).</p> <p>3) Added a new EOC: (EOC.04: The hospital ensures sterility of any parenteral administration).</p>
IPC.09 KW: Environmental cleaning, evidence-based guidelines	IPC.10 KW: Environmental cleaning, evidence-based guidelines	1) Modified standard statement: (Environmental cleaning and disinfection activities are aligned with

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<p>current national/international guidelines).</p> <p>2) Added new EOCs:</p> <ul style="list-style-type: none"> • (EOC.01: Hospital has approved cleaning and disinfection policy, and procedures includes items from a) to e) in the intent). • (EOC.03: The hospital identifies high risk areas with different schedules for each area and includes all elements mentioned in the intent from i) through iii). <p>3) Modified EOC: (EOC.04: The Cleaning technique and disinfectant of choice match the requirements of each cleaned area according to the approved policy).</p>
IPC.10 KW : Sterile technique, Aseptic technique	IPC.11 KW : Sterile technique, Aseptic technique	<p>10) Added new EOCs:</p> <ul style="list-style-type: none"> • (EOC.01: Hospital has approved aseptic techniques policy(s) and procedures and include(s) items from a) to c) in the intent). • (EOC.04: Patient preparation is done according to the type of procedures and the hospital policy) <p>11) Modified EOC: (EOC.02: Healthcare professionals are trained and educated on aseptic techniques relevant to their jobs and according to the policy).</p>
IPC.11 KW: Care bundles		2) New standard
IPC.12	IPC.12	1) Modified EOC

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
KW: Transmission based precautions.	KW: isolation precautions	<p>(EOC.03: The hospital has one or more standardized isolation room(s) according to the hospital capacity and at least one AIIR).</p> <p>1. Added a new EOC (EOC.04: Required transmission-based precautions are implemented according to national and international guidelines during hospital stay and during transfer).</p>
IPC.13 KW immunocompromised hosts, protective environment	IPC.13 KW: immunocompromised hosts, protective environment	<p>1)Added new EOC: (EOC.01: The hospital has admission criteria for patients who require a protective environment (PE)).</p> <p>2)Modified EOC: (EOC.02: Involved health care professionals are trained and aware of the required precautions for PE).</p> <p>3)Rephrased EOC: (EOC.05: Precautions during the transfer of patient outside PE are considered).</p>
IPC.14 KW: Sterilization/disinfection	IPC.14 KW: Disinfection, sterilization	<p>1) Added new EOC: (EOC.02: Healthcare professionals involved in sterilization are competent).</p>
IPC.15 KW: Disinfection/Sterilization quality control program	IPC.15 KW: Disinfection/Sterilization quality control program	<p>1) Added a new EOC: (EOC.02: The process of disinfection/sterilization quality control addressing all elements in the intent from i) through vii).</p> <p>2) Updated EOC.04 by merging two EOCs (EOC.02 and EOC.04) in Hospital edition 2021</p> <p>3) Updated EOC.05 by merging two EOCs (EOC.05 and EOC.06) in Hospital edition 2021</p>

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
IPC.16 KW: Laundry service, textile	IPC.16 KW: Laundry service, textile	1) Modified EOCs: <ul style="list-style-type: none"> • (EOC.02: Contaminated textiles are collected, stored and transported according to the policy). • (EOC.03: There is at least one functioning washing machine with specification complying with national/international guidelines).
IPC.17 KW: Surveillance, Healthcare associated infections.	IPC.18 KW: Surveillance, Healthcare associated infections.	1) Rephrasing of standard statement to be: (The hospital has established a healthcare-associated infections surveillance process). 2) Modified EOC: (EOC.03: The IPC committee reviews the surveillance process data at least quarterly). 3) Updated EOC.04 by merging two EOCs (EOC.03 and EOC.05) in Hospital edition 2021
IPC.18 KW: Outbreaks investigation	IPC.19 KW: Outbreaks investigation	1) Rephrasing EOC: (EOC.02: The hospital reports patients with suspected communicable diseases as required by laws and regulations). 2) Updated (EOC.04) by merging two EOCs (EOC.05 and EOC.06) in Hospital edition 2021
IPC.19 KW: Multi-Drug-Resistant Organisms	IPC.20 KW: Multi-Drug-Resistant Organisms	1) Modified EOC: (EOC.01: The hospital has an approved policy for MDRO spread control.) 2) Added a new EOC (EOC.03: The hospital identifies and monitor MDROs).
IPC.20 KW: Food Services	IPC.21 KW: Food Services	1) Rephrasing of standard statement to be: (The hospital has a process to ensure safe food services). 2) Modified EOC (EOC.01: The hospital has an approved policy guiding safe

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<p>food services, that addresses all the elements mentioned in the intent from a) through h), and involved staff members are aware of the approved policy)</p> <p>3) Added new EOCs:</p> <ul style="list-style-type: none"> • (EOC.04: Expressed breast milk and formula are handled according to guidelines and hospital policy) • (EOC.05: Administration of feeding tube nutritional therapy is performed according to policy and procedure).
IPC.21 KW: Post-mortem care	IPC.22 KW: Post-mortem care	1) Modified standard statement (Post-mortem care is managed according to guidelines, laws, and regulations).

Efficient structure of the infection prevention and control program

IPC.01 A dedicated team of qualified healthcare professionals oversees infection prevention and control activities according to applicable laws and regulations and national and international guidelines.

Effectiveness

Keywords:

Infection prevention and control (IPC) Team, certification, IPC qualification and training

Intent:

The presence of a qualified and dedicated IPC team in the hospital ensures increased effectiveness of the IPC program in all its phases, including development, implementation, and monitoring.

To ensure the infection prevention and control program effectiveness, a qualified team develops a program, supervises it, puts an action plan in place to implement this program, and educates all staff members on their roles in it. The team leader should be a competent healthcare professional (physician, dentist, or pharmacist) and qualified with at least an IPC diploma. The team members' qualifications, training and numbers meet the hospital's needs. These needs are driven by the hospital's size, complexity of activities, and level of risks, as well as the program's scope.

Survey process guide:

- GAHAR surveyor may review the infection control structure to ensure that it is included in the organization chart.
- GAHAR surveyor may review the approved team formation decision for dedicated staff.
- GAHAR surveyor may interview dedicated staff.
- GAHAR surveyor may review staff files of Infection prevention and control (IPC) dedicated team leader and members to check their job descriptions, certifications, or qualifications.

Evidence of compliance:

1. There is an assigned dedicated IPC team.
2. The IPC team leader is a competent healthcare professional.
3. The IPC team members are qualified and trained.
4. The IPC team member(s) has the ability to communicate with the hospital management and all functioning departments.

Related standards:

IPC.02: IPC program, risk assessment, guidelines; IPC.03: IPC Committee meeting , WFM.04 Job description, WFM.05 Verifying credentials, WFM.09 Staff performance evaluation ,WFM.03 Recruitment process .

IPC.02 A comprehensive infection prevention and control program is developed, implemented, and monitored.

Safety

Keywords:

IPC program, risk assessment, guidelines

Intent:

Healthcare-associated infections are common risks encountered in any hospital. 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 hospital 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 hospital and cover patients, staff, and visitors.

The hospital 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) Surveillance and monitoring system to monitor healthcare-associated infections (HAIs) and track infection rates within the hospital,
- e) Staff education and training on infection control principles and practices,
- f) Outbreak management
- g) Staff immunization,
- h) Antibiotic stewardship program to promote the appropriate use of antimicrobial agents,
- i) Continuously assess and improve infection control practices within the hospital.

The infection prevention and control program's policies and procedures are essential for its effective implementation.

The following list comprises the minimum policies that should be included in any IPC program:

- i. Hand hygiene policy.
- ii. PPE policy.
- iii. Environmental cleaning and disinfection policy.
- iv. Processing of patient care equipment policy and its monitoring.
- v. Safe injection policy.
- vi. Cough etiquette respiratory hygiene policy.
- vii. Surveillance policy.
- viii. Linen management.
- ix. Waste management.
- x. Aseptic techniques policy.
- xi. Transmission based precautions.
- xii. Occupational health program

Survey process guide:

- GAHAR surveyor may review an infection control program to ensure that it is based on the risk assessment, covers all hospital 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 hospital 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 hospital areas and covers patients, visitors, and staff.
5. The hospital monitors the reported data on the infection control program and takes actions to control or improve the processes as appropriate.

Related standards:

IPC.01: Infection prevention and control (IPC) Team, certification, IPC qualification and training, IPC.03: IPC Committee. IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, IPC.08: Safe injection practices, IPC.09: Environmental cleaning, evidence-based guidelines, IPC.12: Transmission based precautions, IPC.14: Sterilization/disinfection, IPC.17: Surveillance, Healthcare-associated infections, IPC.18 Outbreaks investigation, QPI.9 Risk Management Program, QPI.06 Clinical Performance Measures, WFM.07 Orientation Program, WFM.08 Continuous Education Program, EFS.07: Safety Management Plan.

IPC.03 The hospital establishes a functioning multidisciplinary IPC committee that meets at least monthly.

Effectiveness

Keywords:

IPC committee meetings

Intent:

IPC challenges continuously arise in the different hospital disciplines, which in turn provide input for the IPC team to evaluate the situation continuously. Stakeholders and process owners are then involved in the decision-making stage; thus, the presence of a multidisciplinary IPC committee is crucial in order to provide a continuous link between the upper managerial level, the IPC team, and all other hospital departments.

There is a structured infection control committee; all relevant disciplines should be represented in the committee, including (but not limited to) the medical department, nursing services, housekeeping, laboratory, pharmacy, and sterilization services, 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 healthcare-associated infections (HAIS).
- b) Surveillance methods and process
- c) Strategies to prevent infection and control risks.
- d) Reporting infection prevention and control activities

- e) Reviewing and evaluating outbreaks or clusters of HAIS and recommending appropriate control measures.
- f) Collaborating with relevant departments to ensure compliance with infection control standards and regulations.
- g) Annual reviewing and evaluation of the program.

Survey process guide:

- GAHAR surveyor may review an approved IPC committee formation decision, recorded monthly meeting minutes (of the previous six months) and recommendations as well as records to prove follow-up

Evidence of compliance:

1. There are clear terms of reference for the infection control committee that include at least from a) to g) in the intent.
2. All relevant disciplines are represented in the committee.
3. The committee meets at least monthly.
4. The committee minutes are recorded.
5. Implementation of the decisions taken by the committee at the end of each meeting is followed up.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.01: Infection prevention and control (IPC) Team, certification, IPC qualification and training , OGM.05:Committee structure , OGM.04 : Hospital Director, OGM.08 :Hospital leaders QPI.01 Quality Committee (s).

Safe standard precautions

IPC.04 GSR.22 professional hand hygiene guidelines are adopted and implemented throughout the hospital in order to prevent healthcare-associated infections.

Safety

Keywords:

Hand Hygiene

Intent:

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: washing hands with plain or antimicrobial soap and water
- Hygienic hand rub: 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, and persistent activity is not necessary.
- Surgical hand antisepsis/surgical hand preparation/ presurgical hand preparation: antiseptic handwash 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 hospital 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 Jewellery.
- 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 hospital 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 hospital has approved Hand Hygiene policies and procedures based on current professional 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 hospital 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, risk assessment, guidelines, IPC.06: Detergents, antiseptics, and disinfectants, WFM.08: Continuous Education Program, QPI.06: Clinical Performance Measures, WFM.09: Staff Performance Evaluation.

IPC.05 Personal protective equipment is available and used when indicated.

Safety

Keywords:

PPE, guidelines, Physical Barriers

Intent:

Wearing personal protective equipment (PPE) is an important tool in the protection of both patients and healthcare professionals.

PPE term refers to the availability and appropriate use of barriers that a susceptible host may wear to provide a physical barrier between him/her and an infectious agent/infected source.

PPE include gloves, gowns, masks, facial protection, eye protection (including face shields or masks with visor attachments) and respirators.

Proper selection of PPE depends on risk assessments performed at the points of care, so staff education and training are of the utmost importance.

The hospital shall develop and implement a personal protective equipment policy that includes at least the following:

- a) Different types of personal protective equipment (PPE).
- b) Standardized product specifications of Personal protective equipment (PPE).
- c) Personal protective equipment (PPE) use is based on the risk assessment.
- d) Staff education and training on the proper way and sequence of donning and doffing of various PPE.
- e) Monitoring the compliance.

Survey process guide:

- GAHAR surveyor may observe to check the availability and accessibility of PPE.
- GAHAR surveyor may interview staff members to ask about the constant availability, accessibility, and proper use of PPE.
- GAHAR surveyor may observe staff compliance with proper selection and use of PPE according to the patient's suspected infection and/or procedure.
- GAHAR surveyor may review PPE standardized product specifications and disbursement permits.

Evidence of compliance:

1. The hospital has a personal protective equipment policy that includes items mentioned in the intent from a) through e).
2. The choice of PPE to be purchased is based on standardized product specifications.
3. The hospital provides PPE that is easily accessible and appropriate to the task.
4. Hospital staff is trained on the proper way and sequence of donning and doffing of various PPE.
5. Proper selection and use of PPE according to the patient's suspected infection and/or procedure.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.09: Environmental cleaning, evidence-based guidelines, IPC.04: Hand Hygiene, IPC.12: Transmission based precautions, IPC.14: Sterilization/disinfection, WFM.08: Continuous Education Program, WFM.09: Staff Performance Evaluation, QPI.06: Clinical Performance Measures.

IPC.06 Detergents, antiseptics, and disinfectants are available, selected and used according to current national/international guidelines.

Safety

Keywords:

Detergents, antiseptics, and disinfectants

Intent:

Detergents, antiseptics, and disinfectants must always be available in the appropriate places and sufficient amounts.

The availability of these products helps in the implementation of several items of standard precautions like hand hygiene, environmental cleaning and disinfection, and aseptic techniques, all of which are crucial for effective infection control.

Detergents, antiseptics, and disinfectants are selected based on standardized prerequisite specifications. Their effective and appropriate use depends on risk assessment at the point of care, and staff education and training are mandatory for proper use.

Survey process guide:

- GAHAR surveyor may observe to check the availability, accessibility and use of detergents, antiseptics, and disinfectants in the relevant areas and ensure their compatibility with standardized product specifications.
- GAHAR surveyor may review disbursement permits of detergents, antiseptics, and disinfectants.

Evidence of compliance:

1. The choice of purchased detergents, antiseptics, and disinfectants is based on standardized product specifications.
2. The hospital provides detergents, antiseptics, and disinfectants that are readily available, easily accessible, and appropriate to the task.
3. Selection and use of antiseptics and disinfectants according to the patient's suspected infection and according to the required procedure.
4. Antiseptics and disinfectants are stored in appropriate areas that are easily accessible.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.09: Environmental cleaning, evidence-based guidelines, IPC.04: Hand Hygiene, OGM.10 Supply Chain Management, EFS.06 Hazardous materials safety.

IPC.07 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 hospital 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 a hospital with signs of respiratory illness, including cough, congestion, rhinorrhoea, or increased production of respiratory secretions.

Respiratory hygiene and cough etiquette interventions (alcohol rub, tissues, surgical masks, and posters) should be present in all entries of the hospital and all waiting areas.

Survey process guide:

- GAHAR surveyor may observe to ensure the availability of respiratory hygiene/cough etiquette posters in appropriate places.
- GAHAR surveyor may observe to ensure accessibility and use of detergents, antiseptics, and disinfectants in the relevant areas and the availability and accessibility of the relevant resources in proper places.
- GAHAR surveyor may observe the assigned areas for patients with suspected respiratory infections and ensure compliance with respiratory patient placement.

Evidence of compliance:

1. Respiratory hygiene/cough etiquette supplies are displayed at appropriate places.
2. Resources such as tissues and surgical masks are available in numbers matching patients' and staff members' needs.
3. The hospital designates a space for patients with suspected respiratory infections to separate them from others.
4. Patients with suspected respiratory infections are identified and placed in the designated areas.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.12: Transmission based precautions, IPC.05: PPE, guidelines, Physical Barriers, IPC.09: Environmental cleaning, evidence-based guidelines, IPC.06 Detergents, antiseptics, and disinfectants, WFM.08 Continuous Education Program.

IPC.08 The hospital ensures Safe injection practices.

Safety

Keywords:

Safe injection practices

Intent:

In the hospital, both inpatients and outpatients are continuously in need of injections, whether for diagnostic or therapeutic purposes; unfortunately, however, it carries an associated risk of infection for the patients. Vascular access devices, like cannula or other instruments used to obtain venous or arterial access, are one of the main causes of healthcare-associated infections. The risk of infection is greatly reduced by complying with the process for safe insertion and maintenance of the device and its removal as soon as it is no longer needed.

Moreover, needle stick injury among healthcare professionals is a common accident, so safe injection practices are crucial to ensure both patient and healthcare professionals' safety.

Healthcare professionals must always use a sterile, single-use disposable syringe or needle for each injection given and ensure that all injection equipment and medication vials remain free from contamination. Healthcare professionals must also consider that all ampoules, by default, are single-use, not all vials are multi-dose vials, and syringes should not be used as a container or storage of drugs.

Survey process guide:

- GAHAR surveyor may observe to check the availability of Intravenous bottles and ensure their proper use of single-dose vials and the proper use of multi-dose vials.
- GAHAR surveyor may observe to ensure the compliance of responsible healthcare professionals with safe insertion and maintenance of the vascular access device procedures.

Evidence of compliance:

1. The intravenous bottles/bags are not used interchangeably between patients.
2. Use of single-dose vials versus multi-dose vials follows regulations and hospital-approved clinical guidelines.
3. The hospital ensures single use of the fluid's infusion.
4. The hospital ensures sterility of any parenteral administration.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, QPI.9 Risk Management Program, QPI.10: Incident Reporting System, OGM.17: Staff Health program, WFM.08 Continuous Education Program.

IPC.09 Environmental cleaning and disinfection activities are aligned with current national/international guidelines.

Safety

Keywords:

Environmental cleaning, evidence-based guidelines

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 hospital can easily lead to cross-contamination of microorganisms between the environment and healthcare professionals.

The determination of environmental cleaning and disinfection procedures for individual patient care areas, including frequency, method, and process, should be based on the risk of pathogen transmission. This risk is a function of the:

- probability of contamination
- vulnerability of the patients to infection
- potential for exposure (i.e., high-touch vs low-touch surfaces)

To provide quality care, the hospital must have a clear method and schedule for environmental cleaning and disinfection, including walls, floors, ceilings, and furniture. Medical equipment should be cleaned on a regular schedule with an approved disinfectant based on the manufacturer's recommendations for use. Cleaning activities and times are listed for each area. The schedule must address environmental cleaning activities for each area as follows:

- i. Activities to be done every day.
- ii. Activities to be done every shift.
- iii. Deep cleaning activities

The hospital 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:

- GAHAR surveyor may review the hospital policy guiding environmental cleaning and disinfection
- GAHAR surveyor may review the hospital list of all environmental services that require cleaning, cleaning schedules and spill kits.
- GAHAR surveyor may interview healthcare professionals and environmental cleaning staff members to ask about the availability, accessibility, and use of disinfectant and spill kits properly.

Evidence of compliance:

1. The hospital 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 hospital identifies high-risk areas with different schedules for each area and includes all elements mentioned in the intent from i) through iii).
4. The cleaning technique and disinfectant of choice match the requirements of each cleaned area according to the approved policy.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, IPC.06 Detergents, antiseptics, and disinfectants, EFS.06 Hazardous materials safety, WFM.08 Continuous Education Program.

IPC.10 Current evidence-based aseptic techniques are followed during all medical procedures.

Safety

Keywords:

Sterile technique, Aseptic technique

Intent:

Asepsis is a basic infection prevention method, as well as an important factor in patient safety in medical practice. Asepsis is defined as the process of keeping away disease-producing microorganisms. It is implemented to protect the patient by minimizing contamination to reduce the risk of infection.

The aseptic technique refers to practices designed to render and maintain objects and areas maximally free from microorganisms. The aseptic technique is adaptable to minimize the risk of infection transmission. This technique prevents contamination from person to person, from one body site to another and from the environment to the patient.

The term 'aseptic technique' encompasses several key elements: a 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. The choice of the level of antisepsis shall be based on a risk assessment.

- Surgical asepsis is using 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.
- 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 of avoiding infection remains in all clinical settings.
- 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 hospital shall develop and implement an aseptic techniques policy and procedures based on current evidence-based 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 hospital policy guiding aseptic techniques. To assess developed policies and procedures.
- GAHAR surveyor may interview healthcare professionals to ask about how they choose and perform aseptic techniques properly in relevant departments.
- GAHAR surveyor may review healthcare professional's training records.
- GAHAR surveyor may observe the places and practices of performing aseptic techniques in the relevant departments.

Evidence of compliance:

1. Hospital has approved aseptic techniques policy(s) and procedures and include(s) items from a) to c) in the intent.
2. Healthcare professionals are trained and educated on aseptic techniques relevant to their jobs and according to the policy.
3. Various aseptic techniques are performed in the hospital according to evidence-based guidelines.
4. Patient preparation is done according to the type of procedures and the hospital policy.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, IPC.09: Environmental cleaning, evidence-based guidelines QPI.9 Risk Management Program, WFM.08 Continuous Education Program.

IPC. 11, the hospital ensures implementation of evidence-based and /or best practices care bundles.

Safety

Keywords:

Care bundles

Intent:

Care “bundles” are simple sets of evidence-based practices that, when implemented collectively, improve the reliability of their delivery and improve patient outcomes. A number of specific bundles are available that can be implemented at healthcare facilities in resource-limited settings. These packages of care contribute to infection prevention, reduce unnecessary antibiotic prescribing, and may limit the development of antibiotic resistance in healthcare facilities.

Bundles also help to create reliable and consistent care systems in hospital settings since they are simple (three to five elements), clear, and concise. In addition, the implementation of bundles also promotes multi-disciplinary collaboration since they should be developed collaboratively, and consensus should be obtained with strong clinician engagement and endorsement.

In order for bundle implementation to be successful, each element of the bundle must be implemented collectively and consistently to achieve the most favourable outcomes (“all or none” approach).

The effective implementation of a care bundle requires that the measures be adapted to the local setting, appropriately followed, entrenched in the patient care culture, and recorded and evaluated to ensure compliance by all members of the healthcare team involved.

The hospital shall develop and implement a policy and procedures guiding evidence-based care bundles to address measures included in at least the following: -

- a) Bundles for the prevention of central line-associated bloodstream infections (CLABSI)
- b) Bundle for the prevention of catheter-associated urinary tract infections (CAUTI)
- c) Bundle for the prevention of ventilator-associated pneumonia (VAP)
- d) Bundle for the prevention of surgical site infection (SSI)

Survey process guide:

- The GAHAR surveyor may review the hospital policy guiding evidence-based care bundles and review the evidence-based selected measures for each bundle.
- The GAHAR surveyor may interview involved staff members to ensure their awareness of how to follow each bundle element for each patient.
- The GAHAR surveyor may review a sample of patients' medical records to check the bundles implementation and bundles implementation monitoring records.
- The GAHAR surveyor may observe the impact of bundled interventions on how they improve the “culture” of patient safety and promote teamwork.

Evidence of compliance:

1. The hospital has an approved process to collectively implement all elements of preventive care bundles.
2. Involved staff members are aware and educated on all elements of the bundles.
3. The hospital monitors implementation and compliance with bundles.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, IPC.09: Environmental cleaning, evidence-based guidelines IPC.12: Transmission based precautions, IPC.10: Sterile technique, Aseptic technique, IPC.08 Safe injection practices, QPI.9: Risk Management Program.

Safe transmission-based precautions and precautions for immunocompromised hosts

IPC.12 Patients with clinically suspected and/or confirmed communicable diseases follow transmission-based precautions according to mode(s) of transmission.

Safety

Keywords:

Transmission based precautions.

Intent:

Transmission-based precautions (TBPs) are used in addition to standard precautions when standard precautions alone may be insufficient to prevent transmission of infection. TBPs are used for patients known or suspected to be infected or colonized with epidemiologically important or highly transmissible pathogens that can transmit or cause infection.

Transmission-based precautions create barriers between people and microorganisms that help prevent the spread of germs in the hospital. They also include appropriate patient placement and appropriate PPE selection, and use based on risk assessment.

There are three main categories of Transmission-Based Precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions.

Once the patient is determined to be at an increased risk for transmission of microorganisms, the patient should be placed in the hospital's standardized isolation room. The hospital's standardized isolation room is a separate, well-ventilated room equipped with a hand-washing basin, a private bathroom, a self-contained door and extractors to extract air outside the facility. In addition, this room must be located far from the rest of the patient care areas, with no pressure specifications required for the ventilation system. At least one standardized isolation room should be available in the ER for suspected infections.

When such standardized isolation room(s) is not currently available, the patient should be separated into separate assigned areas/rooms.

Concerning patients who present with clinical respiratory syndromes are instructed to practice respiratory hygiene and cough etiquette and given a surgical mask to wear until an examination room can be provided.

Patients with known or suspected airborne infections shall be identified. Such patients requiring airborne precautions are placed in a negative pressure room (AIIR). If a negative pressure room is occupied, place the patient in a room with a portable high-efficiency particulate air (HEPA) filter. If no portable HEPA filter is available, the hospital must ensure the patient's surgical mask is worn.

The hospital must have at least one negative pressure room (AIIR) for airborne infections.

Also, the hospital must have one or more standardized isolation rooms for other transmission-based precautions (droplet and contact).

Regardless of the type of the patient's isolation room, the contacting staff must wear appropriate respiratory protection (such as an N95 respirator) during all patient care time, and regular high-touch surface cleaning and disinfection is standard.

Empiric Precautions are isolation precautions while waiting for a clear diagnosis. Such precautions may be initiated while confirmatory tests are pending (e.g., laboratory cultures), including enteric contact precautions for patients with diarrhoea, airborne precautions for patients with symptoms consistent with tuberculosis, droplet precautions for patients with respiratory symptoms, and contact precautions for patients with wounds or a history of MRSA.

Expanded Precautions are isolation precautions to be used when dealing with highly transmissible or epidemiologically important pathogens that are Easily transmitted along with clusters of infected people (two or more individuals) in an area.

The hospital shall develop and implement a policy and procedures guiding Transmission-based precautions (TBPs) to address the three different categories: contact, droplet and airborne precautions.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding transmission-based precautions.
- GAHAR surveyor may assess to ensure the presence of at least one standardized isolation room(s) and assigned areas for patient placing according to the hospital capacity.
- GAHAR surveyor may interview healthcare professionals to inquire about the use of PPE and hand hygiene practices according to the type of isolation.
- GAHAR surveyor may observe staff compliance with the use of appropriate PPE and hand hygiene practices.

Evidence of compliance:

1. The hospital has an approved policy to guide transmission-based precautions.
2. Healthcare professionals are trained and educated on approved policies.
3. The hospital has one or more standardized isolation room(s) according to the hospital capacity and at least one AIIR.
4. Required transmission-based precautions are implemented according to national and international guidelines during hospital stay and during transfer.
5. Patients with suspected/ confirmed communicable diseases are identified and separated in labelled assigned areas/rooms.
6. 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, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, IPC: Respiratory Hygiene Protocol, cough etiquette, IPC.09: Environmental cleaning, evidence-based guidelines, EFS.11: Utility Management, WFM.08 Continuous Education Program.

IPC.13 A protective environment is provided to immunocompromised hosts depending on their clinical needs.

Safety

Keywords:

Immunocompromised hosts, protective environment

Intent:

An immunocompromised host is an individual who has one or more defects in the body's normal defence mechanisms, hence predisposing him/ her to infections, which may be life-threatening. These individuals continue to be at risk for common infections as well but may pursue a more aggressive course than they might otherwise.

Several categories of immunity compromise exist, and some patients may have more than one type. Need to add clinical definitions and criteria/requirements for a protective environment.

Hematopoietic stem cell transplant recipients demonstrate clear examples of severe immune suppression due to a variety of reasons, including neutropenia, mucositis, and the application of indwelling catheters. A protective Environment (PE) shall be provided, according to national/international guidelines, for hematopoietic stem cell transplant inpatients, including, but not limited to, the following requirements:

- Positive room air pressure in relation to the corridor

- Central or point-of-use high-efficiency HEPA filters capable of removing particles 0.3 µm in diameter to supply (incoming) air.
- Well-sealed rooms.

For patients who require both a PE and Airborne Infection Isolation, use an anteroom to ensure proper air balance relationships and provide independent exhaust of contaminated air to the outside or place a HEPA filter in the exhaust duct. If an anteroom is not available, place the patient in an AIIR and use portable ventilation units and industrial-grade HEPA filters to enhance the spore filtration.

In addition, specially trained staff members who adopt a team approach to infection prevention concerns shall take care of these patients since consistent use of standard precautions as well as transmission-based precautions when indicated is the most important of all interventions. Signage shall be positioned prominently outside the room of a patient in transmission-based precautions. This is to ensure staff and visitors do not enter without appropriate PPE.

Survey process guide:

- GAHAR surveyor may review the hospital admission criteria for the patients requiring a protective environment (PE).
- GAHAR surveyor may interview Involved health care professionals to check their awareness of the required precautions for PE.
- GAHAR surveyor may observe to ensure the presence of a standardized protective environment.
- GAHAR surveyor may observe to ensure compliance with Hand Hygiene and transmission-based precautions during healthcare services provision for immunocompromised hosts.

Evidence of compliance:

1. The hospital has admission criteria for patients who require a protective environment (PE).
2. Involved healthcare professionals are trained and aware of the required precautions for PE.
3. Facility design supports the provision of a safe environment for immunocompromised hosts.
4. Signage is positioned prominently outside the room of a patient in PE.
5. Precautions during the transfer of patients outside PE are considered.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, IPC.09: Environmental cleaning, evidence-based guidelines, EFS.11: Utility Management.

IPC.14 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 hospital.

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 hospital 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 items that come in contact with mucous membranes or non-intact skin, such as gastrointestinal endoscopes, respiratory and anaesthesia equipment, bronchoscopes and laryngoscopes etc. Chemical disinfectants approved for high-level disinfection include glutaraldehyde, orthophthalaldehyde 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 some semi-critical items, most non-critical reusable items may be decontaminated where they are 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 hospital 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 hospital 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 hospital 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.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.05: PPE, guidelines, Physical Barriers, IPC.15: Disinfection/Sterilization quality control program, IPC.06: Detergents, antiseptics, and disinfectants, OGM.10 Supply Chain Management, WFM.08 Continuous Education Program.

IPC.15 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 hospital; 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 analysed and followed up, and preventive actions shall be taken and recorded before major problems arise.

The hospital 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 hospital 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 hospital 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 hospital 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, risk assessment, guidelines, IPC.05: PPE, guidelines, Physical Barriers IPC.14 Sterilization/disinfection, OGM.10 Supply Chain Management, WFM.08 Continuous Education Program.

Safe laundry and healthcare textile management

IPC.16 Laundry service and healthcare textile management are safe.

Safety

Keywords:

Laundry service, textile

Intent:

Procedures that involve contact with contaminated textiles can be a source for introducing pathogens that lead to infection. Failure to properly clean, disinfect, or store textiles puts not only patients but also staff members who transport them at risk of infection.

It is critical that healthcare professionals follow standard practices to clean and disinfect used textiles. Infection risk is minimized with proper cleaning and disinfection processes. The washing machine shall have a pre-cleaning cycle. Healthcare professionals shall follow the manufacturer's instructions for detergent and disinfectant use and washing instructions.

The hospital 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) Water temperature, detergents, and disinfectant usage.
- d) Processes of storage and distribution of clean textiles.
- e) Quality control program (temperature, amount of detergents and disinfectants used, and maintenance) for each washing machine.

Survey process guide:

- GAHAR surveyor may review approved hospital policy to guide the safe laundry and healthcare textile services management.
- GAHAR surveyor may interview involved staff members to check their awareness of the hospital policy.
- GAHAR surveyor may observe to ensure compliance with the approved hospital policy.
- GAHAR surveyor may visit areas where laundry and health textile management is performed to observe its design, the presence of functioning washing machine/s, recorded water temperatures and quality control records.

Evidence of compliance:

1. The hospital has an approved policy to guide the safe laundry and healthcare textile services management that addresses all elements in the intent from a) through e), and involved staff members are aware of the approved hospital policy.
2. Contaminated textiles are collected, stored and transported according to the policy.
3. There is at least one functioning washing machine with specifications complying with national/international guidelines.
4. There are at least three physically separated areas for sorting, washing, and drying and/or storing.
5. A quality control program, including water temperatures, is implemented and recorded.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.05: PPE, guidelines, Physical Barriers, IPC.06: Detergents, antiseptics, and disinfectants, EFS.11: Utility Management, WFM.08 Continuous Education Program.

Effective epidemiological surveillance and monitoring

IPC.17 The hospital has established a healthcare-associated infection surveillance process.

Effectiveness

Keywords:

Surveillance, Healthcare-associated infections.

Intent:

Surveillance is an essential component of an effective IPC program since the use of data contributes to improving the healthcare quality system. Surveillance plays a critical role in identifying outbreaks, emerging infectious diseases, and multidrug-resistant organisms in order to institute appropriate IPC measures.

An effective surveillance process shall be based on comprehensive epidemiological and statistical principles. The hospital reports data on its surveillance process to stakeholders, and reports are reviewed at least quarterly by the IPC committee.

The Hospital Shall develop and implement a policy and procedures guiding the surveillance process.

Survey process guide:

- GAHAR surveyor may review the approved Hospital policy guiding the surveillance process and healthcare professionals' training records.
- GAHAR surveyor may review surveillance documents, quarterly surveillance reports that are reviewed by the IPC committee and recommendations for improvement.
- GAHAR surveyor may assess the implementation of IPC committee recommendations.

Evidence of compliance:

1. The hospital has an approved policy to guide the surveillance process.
2. Healthcare professionals are trained on the approved policy.
3. The IPC committee reviews the surveillance process data at least quarterly.
4. The hospital monitors the reported data on its surveillance process and takes actions to control or improve the process as appropriate.

Related standards:

IPC.02: IPC program, risk assessment, guidelines; IPC.18: Outbreaks investigation, IPC.19: Multi-Drug Resistant Organisms, QPI.06: Clinical Performance Measures, WFM.08 Continuous Education Program.

IPC.18 Outbreaks are investigated and managed according to national guidelines.

Effectiveness

Keywords:

Outbreaks investigation

Intent:

Outbreak is defined as occurrence of disease cases in excess of normal expectations. Outbreaks shall be suspected in cases of increased rate of healthcare associated infections or when new or unusual pathogens are recovered from samples.

Outbreaks of infectious diseases when occur in healthcare settings pose a threat to patient safety. The goal of outbreak investigations is to identify the most probable contributing factors in order to stop the outbreaks and prevent their recurrence. Effective management of outbreaks shall require cooperation between infection prevention and control team and other clinical specialties.

The Hospital Shall develop and implement an approved process for outbreak investigations.

The following 10-step approach to investigating an outbreak has been described in the literature:

1. Determine the existence of the outbreak,
2. Confirm the diagnosis,
3. Define a case,
4. Search for cases,
5. Generate hypotheses using descriptive findings,
6. Test hypotheses with an analytical study,
7. Draw conclusions,
8. Compare the hypothesis with established facts,
9. Communicate findings,
10. Execute prevention measures.

Survey process guide:

- GAHAR surveyor may review an approved documented process for outbreak investigations,
- GAHAR surveyor may review healthcare professionals' training records.
- GAHAR surveyor may review the reporting system for notifiable communicable diseases and outbreaks investigation analysis reports.

Evidence of compliance:

1. The hospital has an approved process for outbreak investigations.
2. The hospital reports patients with suspected communicable diseases as required by laws and regulations.
3. Outbreak investigation and management is performed through multidisciplinary efforts.
4. The hospital monitors the reported data on its outbreaks and takes actions to control or improve the process as appropriate.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, IPC.09: Environmental cleaning, evidence-based guidelines IPC.17: Surveillance, Healthcare-associated infections, IPC.12: Transmission based precautions, EFS.13: Disaster Plan, QPI.9: Risk Management Program, WFM.08 Continuous Education Program.

IPC.19 Multi-drug resistant organisms (MDROs) are controlled.

Safety

Keywords:

Multi-Drug Resistant Organisms

Intent:

MDROs have increased in prevalence over the last three decades and have become a global health-threatening problem and have important implications for patients' safety. This concern is due to the extremely limited treatment options for treating patients with these infections. Also, MDRO infections are associated with increased lengths of stay, costs, and mortality.

Successful prevention and control of MDROs require effective administrative and scientific leadership as well as a financial and human resources commitment. Resources shall be provided for infection prevention and control, including expert consultation, laboratory support, adherence monitoring, and data analysis in order to prevent transmission.

The Hospital Shall develop and implement an approved policy and procedures guiding MDRO spread control to address at least the following: -

- a) The definition of Multi-Drug Resistant organisms.
- b) The most common micro-organisms of epidemiological importance.
- c) MDROs containment measures.

Survey process guide:

- GAHAR surveyor may review the approved Hospital policy guiding MDRO spread control.
- GAHAR surveyor may review healthcare professionals' training records.
- GAHAR surveyor may assess compliance with MDRO containment measures such as isolation, monitoring, etc.

Evidence of compliance:

1. The hospital has an approved policy for MDRO spread control,
2. Involved staff are trained on the approved policy.
3. The hospital identifies and monitors MDROs.
4. Measures are taken to control MDRO infection spread.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, IPC.09: Environmental cleaning, evidence-based guidelines MMS.02: Antimicrobial Stewardship Program, IPC.17: Surveillance, Healthcare-associated infections, IPC.12: Transmission based precautions, WFM.08 Continuous Education Program.

Safe food services

IPC.20 The hospital has a process to ensure safe food services.

Safety

Keywords:

Food Services

Intent:

Food services provided by the hospital's kitchen can be a potential source of infection if improperly prepared, handled, and/or stored.

Foodborne illnesses can pose a significant health threat, especially to immunocompromised patients. Consequently, effective IPC measures are crucial to prevent these infections.

Safe food services involve all processes starting from receipt of food and other nutritional products throughout their storage, preparation, handling, and until they are safely delivered.

The hospital shall develop and implement a policy and procedures to guide safe food services that address at least the following:

- a) Food receiving process.
- b) A safe storage process including a food rotation system that is consistent with first-in-first-out principles.
- c) Monitoring of temperature during preparation and storage.
- d) Functioning washing facility in the kitchen
- e) Prevention of cross-contamination of food, whether directly from raw to cooked food or indirectly through contaminated hands, working surfaces, cutting boards, utensils, etc.
- f) Food transportation process.
- g) Preparation, storage, and administration of feeding tube nutritional therapy.
- h) Safe handling and storage of expressed breast milk and formula.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding safe food services.
- GAHAR surveyor may interview involved staff members to check their awareness.
- GAHAR surveyor may assess compliance with the measures for prevention of cross-contamination, such as the presence of separate cutting boards for different types of food and separate areas for receiving, storage, and preparation of food and nutritional products.
- GAHAR surveyor may review recorded food storage temperatures.
- GAHAR surveyor may observe the sanitary food storage, preparation and distribution.

Evidence of compliance:

1. The hospital has an approved policy guiding safe food services that addresses all the elements mentioned in the intent from a) through h), and involved staff members are aware of the approved policy.
2. There are separate areas for receiving, storage, and preparation of food and nutritional products.
3. The hospital prepares and distributes food using proper sanitation and temperatures.
4. Expressed breast milk and formula are handled according to guidelines and hospital policy.
5. Administration of feeding tube nutritional therapy is performed according to policy and procedure.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, EFS.11 Utilities management; OGM.17: Staff Health program, ICD.13: Patient nutritional needs, EFS.03: Fire and smoke safety, WFM.08 Continuous Education Program.

IPC.21 Post-mortem care is managed according to guidelines, laws, and regulations.

Effectiveness

Keywords:

Post-mortem care

Intent:

Post-mortem care includes the processes of preparing the deceased for burial. Post-mortem care presents occupational risks that need to be anticipated and addressed in the policy.

The hospital shall develop and implement a policy and procedures for post-mortem care that includes at least the following:

- a) Infection hazard assessments.
- b) Procedures to minimize these hazards.
- c) Use of appropriate engineering devices and personal protective equipment to minimize exposure.
- d) Sorting of waste.
- e) Record keeping.
- f) Environmental cleaning procedures.
- g) Reporting accidental exposures.

Generally, standard IPC precautions are applied, and any transmission-based precautions that were applied to patients shall be continued after death.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding post-mortem care.
- GAHAR surveyor may interview involved staff members to check their awareness of the hospital policy.
- GAHAR surveyor may observe to ensure compliance with Standard and transmission-based precautions on dead bodies and body parts.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g).
2. Staff members involved in post-mortem care are aware of the approved policy.
3. Post-mortem care practices are implemented according to current evidence-based guidelines,

laws and regulations.

4. Standard and transmission-based precautions are applied on dead bodies and all body parts as applicable.

Related standards:

IPC.02: IPC program, risk assessment, guidelines, IPC.09: Environmental cleaning, evidence-based guidelines, IPC.04: Hand Hygiene, IPC.05: PPE, guidelines, Physical Barriers, IPC.12: Transmission based precautions, WFM.08 Continuous Education Program.

Organization Governance and Management

Chapter intent

This chapter examines the various governance and accountability structures that can vary based on the hospital's size, mandate, and ownership status, whether public or private. Potential governance structures include an individual or group owner, a government committee or ministry, or a board of directors. A clearly defined governing body structure offers clarity to all members of the hospital, including managers, clinical leadership, and staff, by specifying who holds the ultimate decision-making authority and oversight of the hospital's overall direction. While governance provides oversight and support, the effective management of the hospital relies on the dedication and planning efforts of hospital leadership, as well as the leaders of its departments and services.

Effective planning begins with identifying the needs of stakeholders and designing services to meet those needs. The hospital's plans should be continuously aligned with government-initiated campaigns that address therapeutic, prophylactic, social, and nutritional aspects of healthcare. This chapter guides assigning duties to various management levels and ensuring effective communication to achieve the hospital's goals and objectives.

The healthcare landscape is increasingly moving toward a fully quality-driven future and a pay-for-performance model. This chapter focuses on the financial aspects of healthcare, affecting both patients and providers. As value-based care and higher efficiency levels gain prominence, the keys to success in medical practice are evolving swiftly.

The chapter handles various organization-wide topics such as contracted services, ethical management, and staff engagement, which may reflect efficient and effective collaborative management efforts.

GAHAR surveyors, through leadership/ staff interviews, observations, and process evaluation, shall assess the efficiency and effectiveness of the governing body and leadership structure. The ability of leaders to motivate and drive the staff is instrumental to the success of a hospital and can be assessed throughout the survey.

Chapter purpose:

The chapter focuses on checking the hospital structure resilience by looking into the following:

- 1) Effectiveness of governing body
- 2) Effectiveness of direction
- 3) Effectiveness of leadership
- 4) Effectiveness of financial stewardship
- 5) Efficient contract management
- 6) Ethical management
- 7) Effective staff engagement, health, and safety

OGM Chapter Summary of Changes*Summary of Changes Chapter 11*

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
OGM.01 KW: Governing body and Structure responsibilities	OGM.01 KW: Governing body structure OGM.03 KW: Governing body responsibility	1) Updated standard (OGM.01) by merging two standards (OGM.01 and OGM.03) in Hospital edition 2021.
OGM.02 KW: Mission Statement	OGM.02 KW: Mission Statement	3) Modified EOC: (EOC.02: The mission statement is reviewed annually).
OGM.03 KW: Effective communication with governing body	OGM.04 KW: Effective communication with governing body	1) Added a new EOC: (EOC.03: The governing body receives reports as regards hospital performance at least quarterly).
OGM.04 KW: Hospital Director	OGM.05 KW: Hospital Director	5) Modified EOC: (EOC.03: There is a job description for the hospital director covering the standard requirements from a) through i) as in the intent). 6) Rephrasing of EOC: (EOC.05)
OGM.05 KW:Committee structure	OGM.06 KW: Committee structure	7) Modified standard statement: (The hospital develops the required committees by laws and regulation). 8) Added a new EOC: (EOC.05: The performance of committees is reviewed annually).
OGM.06 KW: Strategic Planning	OGM.07 KW: Strategic Planning	2) Rephrasing of EOCs: (EOC.01 & EOC.02). 3) Modified EOC: (EOC.03 The strategic plan is reviewed annually).
OGM.07 KW Operational Planning	OGM.08 KW: Operational Planning	1. Modified EOC: (EOC.02 Staff is aware and participates in developing relevant operational plans).
OGM.08 KW: Hospital leaders	OGM.09 KW: Hospital leaders	No change.

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
OGM.09 KW: Departmental management	OGM.10 KW: Departmental management	No change.
OGM.10 KW: Supply Chain Management	OGM.11 KW: Supply Chain Management	12) Added a new EOC: (EOC.02: Involved staff are aware of the contents of the policy). 13) Modified EOC: (EOC.03: The Supply chain process is recorded, monitored, and evaluated).
OGM.11 KW: Stock Management	OGM.12 KW: Stock Management	3) Rephrasing of standard statement to be: (The hospital has defined processes to manage its storage, stock, and inventory).
OGM.12 KW: Billing System	OGM.14 KW: Billing System PCC.14 KW: patient and family education on administrative process	1) Updated standard (OGM.12) by merging two standards (OGM.14 and PCC.14) in Hospital edition 2021.
OGM.13 KW: Contract Management	OGM.15 KW: Contract Management	No change.
OGM.14 KW: Safety Culture	OGM.16 KW: Safety Culture	1) Added new EOCs: <ul style="list-style-type: none"> • (EOC.01: The leaders are aware of the measures to promote patient safety and quality culture). • (EOC.04: Lesson learned from root cause analysis (RCA) of sentinel events are discussed and communicated). • (EOC.05: The hospital addresses resistance to change and follows a documented approach to manage among hospital staff and other stakeholders). 2) Rephrasing of EOC: (EOC.02)

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		3) Modified EOC: (EOC.03: Leaders creates a no blame/just culture to encourage reporting errors and near misses).
OGM.15 KW: Ethical Management	OGM.18 KW: Ethical Management	<p>4) Rephrasing of standard statement to be: (The hospital establishes a framework to ensure ethical management).</p> <p>5) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.01: The hospital has an ethical committee with terms of references that addresses at least a) to f) in the intent). <p>6) Added a new EOC: (EOC.03: The committee meets regularly, and the minutes of meetings are recorded).</p>
OGM.16 KW: Staff rest areas	OGM.19 KW: Staff Working Condition	2) Rephrasing of standard statement to be: (The hospital ensures availability of staff rest areas).
OGM.17 KW: Staff Health program	OGM.20 KW: Staff Health	1) Rephrasing of EOC: (EOC.03 Staff members are aware of the risks within the hospital environment, their specific job-related hazards, and periodic medical examination).

Effective governing body

OGM.01 The hospital has a defined governing body structure, responsibilities, and accountabilities.

Effectiveness

Keywords:

Governing body structure and responsibilities

Intent:

The governing body is responsible for defining the hospital's direction and ensuring the alignment of its activity with its purpose. It is also responsible for monitoring its performance and future development. In order to ensure the proper governance and efficient management of any organization, its structure has to be well-defined, and members of the governing body are identified by title and name. The governing entity is represented or displayed in an organizational chart that clearly defines lines of authority and accountability. A governing body should be diverse, reflect the community's interests and desired competencies, and evaluate its performance annually. The governing body meets at set intervals, with meeting minutes recorded.

It should consider that in a centralized system, such as university hospitals, one governing body governs several subsidiary organizations. On the other hand, a governing body can be a board of directors, committee, or a single owner in the case of the private sector.

The governing body of a hospital has several responsibilities and accountabilities to ensure the hospital operates effectively, ethically, and in accordance with its mission. These responsibilities include:

- a) Strategic oversight including defining and upholding the hospital's mission, vision, and values, developing, and approving strategic plans, and ensuring long-term sustainability and growth.
- b) Financial stewardship including approving budgets, monitoring financial performance, ensuring appropriate allocation of resources to support the hospital's priorities and objectives, and supporting fundraising efforts and capital campaigns.
- c) CEO selection and evaluation and ensure effective succession planning and leadership development.
- d) Quality and safety including establishment and monitoring of quality improvement initiatives, ensuring the hospital complies with all relevant laws, regulations, and accreditation standards.
- e) Ethical and legal responsibilities that include ensuring compliance with healthcare laws, regulations, and standards, promoting ethical behavior and decision-making within the hospital, and risk management to protect the hospital from potential liabilities.
- f) Community engagement to promote positive relationships with the community, ensure the hospital addresses community health needs, and advocate for policies and initiatives that support the hospital's mission and the health of the community.
- g) Accountability including reviewing and assessing the hospital's performance in meeting its goals and objectives, and ensuring transparency and accountability in reporting to stakeholders, including patients, staff, and the community.

By fulfilling these responsibilities, the governing body ensures the hospital operates efficiently, provides high-quality care, and meets its commitments to patients, staff, and the community.

To ensure effective governance, the governing body should evaluate its performance annually and provide ongoing education and development opportunities for board members to stay informed about healthcare trends and governance practices.

Survey process guide:

- GAHAR surveyor may review the documents that describe the structure and responsibilities of the governing body.
- GAHAR surveyor may review the recorded minutes of meetings.

Evidence of compliance:

1. The governing body structure is represented in the hospital's organizational chart.
2. Members of the governing body are diverse and identified by title and name.
3. The governing body meets at predefined intervals, and minutes of meetings are recorded.
4. The governing body evaluates its performance annually.
5. The responsibilities and accountabilities of the governing body are defined and include items from a) to g) in the intent.
6. The governing body approves the strategic plan, operational plans, quality improvement and patient safety plan, and community assessment and involvement program.

Related standards:

OGM.02 Mission Statement, OGM.04 Hospital director, OGM.08 Hospital leaders, OGM.06 Strategic Planning, OGM.07 Operational planning, QPI.05 Performance Measure, QPI.02 Quality improvement Plan, QPI.9 Risk Management Program, APC.03 Sustaining compliance with accreditation standards, CAI.01 Community involvement program

OGM.02 The governing body works with the hospital leaders to set the hospital mission statement.

Effectiveness

Keywords:

Mission Statement

Intent:

The mission statement is a description of the hospital's core purpose. It is the ground element for establishing the strategic direction of a hospital leading to the formulation of its objectives and related strategies. Defining the main purpose of the hospital e.g., scope of service, specialty, population served, and level of care in the form of a mission is one of the fundamental roles of the governing body. The hospital's mission must be aligned with the national healthcare mission and communicated to all relevant stakeholders, including staff, patients, and visitors.

Survey process guide:

- GAHAR surveyor may observe the mission statement posters, brochures, or documents focusing on its last update, approval, alignment, and visibility.

Evidence of compliance:

1. The hospital has a mission statement approved by the governing body.
2. The mission statement is reviewed annually.
3. The mission statement is visible in public areas to staff, patients, and visitors.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.06 Strategic planning, QPI.02 Quality improvement plan

OGM.03 The hospital leaders ensure effective communication with the governing body.

Effectiveness

Keywords:

Effective communication with the governing body

Intent:

A clear two-way communication process between governance and hospital management ensures that the governing body accurately understands the hospital's performance and associated risks that can hinder the achievement of its goals. In addition, it provides the hospital director the opportunity to report and receive feedback on the hospital's performance, especially those that are problematic.

Hospitals need to define the types of communication channels between the governing body, the management team, and the hospital staff. Communication channels may be in the form of social media, town hall meetings, monthly or annual conferences, or other channels.

Survey process guide:

- GAHAR surveyor may observe evidence of open-defined communication channels, frequency of communication, and evidence of feedback to submitted reports on both sides.

Evidence of compliance:

1. The hospital has a defined process of communication between the governing body and the hospital leaders.
2. The governing body members and hospital leaders are aware of the process of communication and approve the communication channel.
3. The governing body receives reports as regards hospital performance at least quarterly.
4. The governing body submits feedback reports to the hospital director.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital director, OGM.08 Hospital leaders, OGM.09 Departmental management.

Effective organization direction

OGM.04 A full-time qualified director is appointed by the governing body to manage the hospital according to applicable laws and regulations.

Effectiveness

Keywords:

Hospital Director

Intent:

Any organization needs an executive who is responsible and accountable for implementing the governing body's decisions and acting as a link between the governing body and the hospital staff. Such a position requires a dedicated full-time qualified director guided by relevant laws and regulations and/or as further defined by the governing body.

The hospital shall appoint a full-time qualified director and define any leadership delegation authority for managing the hospital in the absence of the hospital director. The hospital 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 hospital's services and hours of operation to the community.
- c) Ensuring that policies and procedures are developed, implemented by leaders, and approved by the governing body.
- d) Providing oversight of human, financial, and physical resources.
- e) Annual evaluation of the performance of the hospital's committees.
- f) Ensuring appropriate response to reports from any inspecting or regulatory agencies, including accreditation.
- g) Ensuring that there is an 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 reporting to the governing body on how legal requirements are being met.

Survey process guide:

- GAHAR surveyor may review the hospital director's job description.
- GAHAR surveyor may review the hospital staff files to check compliance with all required documents of training, job description, role, and responsibilities.
- GAHAR surveyor may review an authority matrix or delegation letters for tasks that the hospital director delegated to any other staff member.
- GAHAR surveyor may interview the hospital director to check his awareness of his responsibilities.

Evidence of compliance:

1. There is a full-time qualified director managing the hospital.
2. There is an appointment letter for the hospital director according to applicable laws and regulations.
3. There is a job description for the hospital director covering the standard requirements from a) through i) as in the intent.
4. The hospital director has appropriate training and/or experience in healthcare management, as defined in the job description.
5. There is evidence of delegation of authority to another competent employee.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.05 Committee structure, OGM.08 Hospital leaders, OGM.06 Strategic Planning, OGM.07 Operational planning, OGM.11 Safety Culture, QPI.05 Performance Measure, QPI.02 Quality improvement Plan, QPI.9 Risk Management Program, APC.03 Sustaining compliance with accreditation standards, CAI.07 Hospital advertisement, CAI.08 Promoting accreditation and quality, WFM.04 Job Description

OGM.05 The hospital develops the required committees by laws and regulations.

Effectiveness

Keywords:

Committee structure

Intent:

Accomplishing the hospital mission requires engagement and teamwork. Such requirements are established through knowledge sharing and staff involvement in decision-making. Committees are tools for mixing distributed knowledge and abilities of various parts of the hospital in the format of one active and integrated team that can have an effective role in decision-making. A multidisciplinary selection of members of every committee and regular holding of committees can enhance its productivity. The hospital leadership, medical staff, nursing staff, and other staff are involved in the relevant committees. 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 hospital has at least the following committees:

- a. Environmental safety committee
- b. Infection control committee
- c. Pharmacy and therapeutic committee
- d. Quality and patient safety committee
- e. Mortality and morbidity committee

Survey process guide:

- GAHAR surveyor may review the terms of reference of each committee.
- GAHAR surveyor may review a sample of meeting minutes of each committee.
- GAHAR surveyor may review the annual evaluation of committees.

Evidence of compliance:

1. The hospital has at least the committees mentioned in the intent a) through e).
2. Each committee has terms of reference.
3. Committees meet regularly.
4. Committees' minutes of meetings are recorded and communicated to involved staff members.
5. The performance of committees is reviewed annually.

Related standards:

EFS.02 Environment and facility safety program monitoring, IPC.03 IPC committee, meetings, MMS.01 Medication management, QPI.01 Quality Committee (s)

OGM.06 A strategic plan is developed under the 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 a hospital's specified vision and mission and attainment of high-level strategic goals. The strategic plan looks out over an extended time horizon, up to 3,5 or 7 years, or maybe more in big organizations.

The plan establishes where the hospital is currently, where leadership wants to go, how they will get there, and how they will know when they have arrived. The strategic plan shall be based on a comprehensive evaluation of the internal and external environmental factors (e.g., SWOT analysis, PEST analysis).

A strategic plan might be established on a higher level (governing body) with the involvement of hospital leaders. It is essential that stakeholders are involved in developing the plan to ensure legitimacy, ownership, and commitment to the plan. The governing body shall approve the strategic plan, and resource allocation for implementation within the hospital.

The strategic plan should be reviewed annually to discuss the progress of goals and objectives and make the necessary adjustments for the upcoming year. The review process usually answers three main questions:

- What has worked and what hasn't worked in the past year?
- What has changed in the hospital's internal or external environment that could have an impact on the strategic plan?
- What would be taken out and what new things would be added to the strategic plan?

Survey process guide:

- GAHAR surveyor may review the hospital's strategic plan.
- GAHAR surveyor may interview the hospital leaders to check their involvement and participation in the development of the strategic plan.

Evidence of compliance:

1. The hospital has a strategic plan with goals and defined objectives.
2. Hospital leaders, community, and other identified stakeholders participate in developing the strategic plan.
3. The strategic plan is reviewed annually.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital Director , OGM.08 Hospital leaders, CAI.05 Community Initiatives

OGM.07 Operational plans are developed to achieve the strategic plan goals and objectives.

Efficiency

Keywords:

Operational Planning

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) SMART objectives.
- b) Specific activities and tasks for implementation.
- c) Timetable for implementation.
- d) Assigned responsibilities.
- e) Sources of the required budget.

SMART objective stands for Specific, Measurable, Achievable, Relevant, and Time-bound. Defining these parameters as they are relevant to the goal helps ensure that objectives are attainable within a certain time frame. SMART objective allows managers and employees to know that they are accomplishing what they set out to accomplish.

The operational plans should be approved by the governing body. Leaders regularly assess the operational plans to determine the required hospital and equipment needs for the next operational cycle. Any planning 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, better-called lessons learned, should feed into the new cycle of planning to improve the hospital's performance.

Survey process guide:

- GAHAR surveyor may interview staff and leaders to check their awareness of the operational plan and participation in developing related operational plans and give them the opportunity to talk about their inputs and how they are communicated.
- GAHAR surveyor may review the evidence of monitoring operational plan progress/ progress reports, and actions taken to improve performance.

Evidence of compliance:

1. The hospital has operational plans that include items from a) to e) in the intent.
2. Staff is aware and participates in developing relevant operational plans.
3. The operational plans are reviewed annually.
4. Operational plan progress reports are considered and used for a new cycle of planning.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital Director , OGM.08 Hospital leaders ,QPI.02 Quality improvement Plan, QPI.05 Performance Measure

OGM.08 The responsibilities and accountabilities of the hospital leaders are identified.

Effectiveness

Keywords:

Hospital leaders

Intent:

While another standard addresses hospital director's responsibilities, hospitals usually have a nursing director, medical director, information officer, financial director, and sometimes operational director, who also carry a lot of weight. The top executives form the central core management.

The hospital leaders shall be qualified, as documented in their job description, and familiar with the concepts of performance improvement and patient safety. The hospital shall establish administrative authorities and responsibilities for hospital leaders that include the following:

- a. Sustaining firm hospital structure:
 - Planning for upgrading or replacing systems, buildings, or components needed for continued, safe, and effective operation.
 - Collaboratively developing a plan for staffing the hospital that identifies the numbers, types, and desired qualifications of staff.
 - Providing appropriate facilities and time for staff education and training.
 - Ensuring all required policies, procedures, and plans have been developed and implemented.
 - Providing adequate space, equipment, and other resources based on strategic and operational plans and needed services.
 - Selecting equipment and supplies based on defined criteria that include quality and cost-effectiveness.
- b. Running smooth directed operations:
 - Creating a "Just Culture" for reporting errors, near misses, and complaints, and using the information to improve the safety of processes and systems.
 - Designing and implementing processes that support continuity, coordination of care, and risk reduction.
 - 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:
 - Ensuring that all quality control monitoring is implemented, monitored, and action is taken when necessary.
 - Ensuring the hospital meets the conditions of facility inspection reports or citations.
 - Annually assessing the operational plans of the services provided to determine the required facility and equipment needs for the next operational cycle.
 - Annually reporting to the hospital governing body or authority on system or process failures and near misses, and actions are taken to improve safety, both proactively and in response to actual occurrences. The hospital data are reviewed, analyzed, and used by management for decision-making.
- d. Continuous Improvement

Survey process guide:

- GAHAR surveyor may interview hospital leaders to check their awareness of their roles and responsibilities.
- GAHAR surveyor may review the hospital leaders' job descriptions

Evidence of compliance:

1. There is a job description for each hospital leader to identify the required qualifications and responsibilities.

2. The responsibilities of the hospital leaders include at least a) through d) in the intent.
3. Hospital leaders are aware of and perform their responsibilities.
4. Hospital leaders submit periodic reports on their activities.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital Director, OGM.06 Strategic Planning, OGM.07 Operational planning, OGM.11 Safety Culture, WFM.04 Job Description, WFM.09 Staff Performance Evaluation, WFM.08 Continuous Education Program, CAI.08 Promoting accreditation and quality, OGM.11 Safety Culture, QPI.05 Performance Measure, QPI.02 Quality improvement Plan, QPI.9 Risk Management program.

Effective departmental leadership

OGM.09 A designated qualified staff member is assigned to supervise each department and service with defined responsibilities.

Effectiveness

Keywords:

Departmental management

Intent:

An effective and efficient department/service supervisor ensures that department services are known and aligned with other department services and that there are adequate resources to offer them.

Each department or service must have a designated staff member responsible for delivering the required services as defined by the hospital mission and related plans to ensure alignment between departments/services and with the hospital as a whole.

The responsibilities of the designated supervisor of each department and service are defined in writing and include at least the following:

- a) Defining a written description of the services provided by the department (scope of service).
- b) Recommending space, staffing, and other resources needed to fulfill the department's approved scope of service.
- c) Recommending staff minimum number and qualifications required according to workload and approved scope of service.
- d) Defining education, skills, and competencies needed by each category of staff.
- e) Ensuring that there is a department-specific orientation and continuing education program for the department's staff.
- f) Ensuring coordination and integration of these services with other departments when relevant.
- g) Ensuring that the department's/service's performance is monitored and reported at least quarterly to leadership.
- h) Ensuring that the department is involved in the performance improvement, patient safety, and risk management program(s).

Survey process guide:

- GAHAR surveyor may review each department/ service supervisor's job description.
- GAHAR surveyor may interview department and services heads to check their awareness of their roles and responsibilities.

Evidence of compliance:

1. There is a job description for each department/ services supervisor to identify the required qualifications and responsibilities.
2. There is a supervisor for each department of the hospital who is qualified as required by the job description.
3. The responsibilities of the departments/ services supervisor include at least a) to h) in the intent.
4. Departments and services heads are aware of and perform their responsibilities.
5. Departments and services heads submit periodic reports on their activities.

Related standards:

OGM.08 Hospital leaders, WFM.04 Job Description, WFM.02 Staffing Plan, WFM.07 Orientation Program, WFM.08 Continuous Education Program, QPI.05 Performance Measure, QPI.02 Quality improvement Plan, QPI.9 Risk Management program.

Efficient financial stewardship

OGM.10 The hospital defines supply chain management processes.

Efficiency

Keywords:

Supply Chain Management

Intent:

The supply chain generally refers to the resources needed to deliver goods or services to a consumer. The supply chain includes all the steps such as sourcing raw materials, manufacturing, distribution, and delivery.

In healthcare, the supply chain involves several independent stakeholders, including manufacturers, insurance companies, hospitals, providers, group purchasing organizations, and regulatory agencies. Both physical goods and information about medical products and services must navigate through these stakeholders.

By promoting efficiency in the healthcare supply chain, hospitals, and physician practices can create substantial cost-reducing opportunities across their organization.

The hospital shall develop a policy and procedures for Supply Chain Management that addresses at least the following:

- a) Supplier's identification and selection process.
- b) Suppliers are monitored and evaluated to ensure that the purchased supplies are provided from reliable sources that refrain from dealing with counterfeit, smuggled, or damaged supplies.
- c) Suppliers are also evaluated based on their response upon request, quality of received materials, check for matching predefined acceptance criteria, LOT number, and expiry date.
- d) Supplies are monitored and evaluated to ensure that no recalled medications, samples, devices, medical supplies, or equipment are provided.
- e) Transportation of supplies is monitored to ensure that it occurs according to applicable laws and regulations, approved organization policy, and manufacturer's recommendations.

Survey process guide:

- GAHAR surveyor may review the supply chain management policy.
- GAHAR surveyor may interview the responsible staff to check their awareness of the policy.
- GAHAR surveyor may review a sample of supply chain records to check, assess, and evaluate the process.

Evidence of compliance:

1. An approved policy addresses all elements from a) through e).
2. Involved staff are aware of the contents of the policy.
3. The supply chain process is recorded, monitored, and evaluated.
4. Suppliers are monitored and evaluated at least annually.

Related standards:

OGM.04 Hospital Director , OGM.08 Hospital leaders, DAS.12 Reagent Management, OGM.13 Contract Management, MMS.03 Medication Procurement, Formulary, EFS.11 Utilities Management plan, EFS.10 Medical Equipment Plan

OGM.11 The hospital has defined processes to manage its storage, stock, and inventory.

Efficiency

Keywords:

Stock Management

Intent:

Inventory is the stock of any item or resource used in a hospital, while storage refers to the physical space where items are kept or preserved for future use.

An inventory system is a set of policies and controls that monitor levels of inventory and determine what levels should be maintained when stock should be replenished.

Inventory control is essential to achieve the aim of the right materials in the right quantity at the right price and in the right place, and it is essential for the appropriate utilization of existing resources.

Unavailability of the needed supplies can adversely affect the hospital operation and cause serious health problems for patients, especially the "critical" hospital resources whose absence is likely to have a major impact on patient outcomes. Thus, the hospital should identify its "critical" resources and ensure their continuous availability. Therefore, inventory control helps in the efficient and optimum use of scarce financial resources, avoiding the shortage of medical materials and eliminating out-of-stock situations.

Effective management of medical stores entails priority setting in the purchase and distribution of medical materials. Using technology like barcode or radio frequency identification (RFID) to streamline data entry, track inventory movement, and improve accuracy is widely used nowadays.

The hospital shall develop a policy and procedures for managing storage, stock, and inventory addresses at least the following:

- a) Compliance of storage to laws, regulations, and organization policies.
- b) Management of stocks safely and efficiently.
- c) Inventory management and tracking of the use of critical resources.
- d) 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 the hospital policy for managing storage, stock, and inventory.
- GAHAR surveyor may interview the responsible staff to check their awareness of the policy.
- GAHAR surveyor may review a sample of storage, stock, and inventory records to check the process.

Evidence of compliance:

1. The hospital has an approved policy for managing storage, stock, and inventory that addresses at least the elements from a) through d) in the intent.
2. As required by laws and regulations, basic information is recorded for stock items as mentioned in the intent from i) through iv).
3. There is an inventory control system that includes identification of utilization rate, re-order limit for each item, and monitoring of out-stock events.
4. The hospital identifies its critical resources and ensures their continuous availability.

Related standards:

DAS.12 Reagent Management, MMS.03 Medication Procurement, Formulary, OGM.10 Supply Chain Management.

OGM.12 The hospital manages the patient billing system.

Efficiency

Keywords:

Billing System

Intent:

The billing process is a crucial component of hospital management. Due to the complexity of the billing processes, billing errors may result in costly financial losses, for example, billing errors due to lack of or inappropriate invoices of medical materials used by the missing barcode due to missing or inappropriate result reports.

The billing process includes that all the services and items provided to the patient are recorded in the patient's account, then all information and charges are processed for billing. For third-party payer systems, the processed for billing is based on the requirements of insurance companies/agencies which generally have reimbursement rules.

The hospital ensures that patients and families are able to understand and participate in administrative processes such as obtaining pre-approval from insurance companies, providing reimbursement, paying deposits, and others. The hospital, on the other hand, should monitor the timeliness of third-party approval.

The hospital shall develop and implement a policy and procedures for the billing process that addresses at least the following:

- a) Availability of an approved price list.
- b) A process to ensure accurate billing.
- c) Use of accurate and approved codes for diagnoses and procedures.
- d) Patients/families are informed of any potential cost pertinent to the planned care.
- e) Patients/families are assisted to understand and manage administrative processes of billing.
- f) Identifying patients whose conditions might require higher costs than expected and providing information to them periodically.

Survey process guide:

- GAHAR surveyor may review the hospital policy and price lists.
- GAHAR surveyor may interview some billing staff and some patients to check their awareness of the policy and the different payment methods.

- GAHAR surveyor may observe the presence of the price list for all provided services in its related areas.

Evidence of compliance:

1. The hospital has an approved policy for billing patients that addresses at least items from a) to f) in the intent.
2. There is an approved price list for healthcare services provided in the hospital.
3. Patients are informed of any potential cost pertinent to the planned care.
4. The hospital uses approved codes for diagnoses and procedures.
5. Billing staff is oriented on various health insurance processes.

Related standards:

OGM.04 Hospital Director , OGM.08 Hospital leaders, PCC.02 Patient and family rights, PCC.03 Patient and family responsibilities, ACT.04 Hospitalization process IMT.02 Information management plan

OGM.13 The hospital implements a process for the selection, evaluation, and continuous monitoring of contracted services.

Effectiveness

Keywords:

Contract Management

Intent:

Hospital leadership shall define the nature and scope of services provided by contracted services, including clinical and non-clinical services, for example, laboratory and radiology services, housekeeping, or catering services.

Head of departments/services shall participate in the selection, evaluation, and continuous monitoring of contracted services to ensure service providers comply with required environmental safety, patient safety, and quality requirements, policies and procedures, and all relevant accreditation standards requirements.

The hospital has to ensure current competency, licensure, education, and continuous improvement of competency for contracted clinical staff.

The contracted services shall be monitored through performance measures and evaluated at least annually to determine if a contract should be renewed or terminated.

Survey process guide:

- GAHAR surveyor may review the approved documents for contracted services.
- GAHAR surveyor may review documents of selection criteria for each service.
- GAHAR surveyor may review performance measures for monitoring contracted services.
- GAHAR surveyor may interview the head of departments/services and responsible staff to check/determine contract monitoring, evaluation, and renewal processes.

Evidence of compliance:

1. There is a list of all contracted services, including clinical and non-clinical services.
2. There are selection criteria for each service.
3. Head of departments/services participates in the selection, evaluation, and monitoring of contracted services.

4. There are performance measures for monitoring contracted services.
5. Each contract is evaluated at least annually to determine if it should be renewed or terminated.

Related standards:

OGM.04 Hospital Director, OGM.08 Hospital leaders, QPI.05 Performance Measures.DAS.29 Contracted blood banks, DAS.13 Outsourced laboratory services, DAS.01 Planning medical imaging services, DAS.19 Laboratory external quality assessment

Safe, ethical, and positive organizational culture

OGM.14 Leaders create a culture of safety and quality within the hospital.

Effectiveness

Keywords:

Safety Culture

Intent:

Creating a culture of safety and quality within a hospital facility requires strong leadership commitment, effective communication, and a sustained effort to ensure patient safety and continuous improvement. There are several strategies to foster such a culture. The hospital 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.

A no-blame culture emphasizes the importance of learning from mistakes and preventing future errors without assigning blame or punishment, while a just culture is a culture where individuals are accountable for their wilful misconduct or gross negligence. A just culture helps create an environment where individuals feel free to report errors and help the organization learn from mistakes. The focus is on identifying system failures, improving processes, and promoting open communication.

However, resistance to cultural change could happen. It is a natural response when individuals feel their routines, comfort zones, or job security are threatened, manifesting as doubt, fear, or opposition. Addressing this resistance is crucial for successful change, fostering a supportive environment and smoother transitions. The hospital is encouraged to adopt a structured approach to understand and

overcome resistance among staff and stakeholders. Models such as Kotter's, Lewin's, and ADKAR can guide organizations in implementing successful change.

Survey process guide:

- GAHAR surveyor may review records of leaders' safety rounds to assess the process
- GAHAR surveyor may interview staff to check support for quality initiatives and safety culture.
- GAHAR surveyors may interview leaders to check their awareness of the measures to promote patient safety and quality 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 root cause analysis (RCA) of sentinel events are discussed and communicated.
5. The hospital addresses resistance to change and follows a documented approach to managing among hospital staff and other stakeholders.

Related standards:

OGM.04 Hospital Director , OGM.08 Hospital leaders, QPI.10 Incident Reporting System, QPI.12 Sustaining Improvement.

OGM.15 The hospital establishes a framework to ensure 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 hospital shall establish and maintain a framework within the hospital that promotes ethical decision-making, integrity, and compliance with legal and professional standards. This involves establishing an ethical committee to oversee ethical practices, address ethical dilemmas within the hospital, and ensure that patient care, staff behavior, and administrative processes are conducted in a morally and ethically responsible manner. The terms of reference of the committee include at least the following:

- a) Development of the hospital values and code of ethics.
- b) Awareness and training of the staff relevant to ethical practices and medicolegal issues.
- c) Management of medical ethical dilemmas.
- d) Identifying and disclosing conflict of interest.
- e) Management of discrimination, and harassment.
- f) Ensuring gender equality.

All ethical issues shall be reported, resolved, and communicated to the responsible stakeholders within a defined timeframe.

Survey process guide:

- GAHAR surveyor may review the terms of reference and meeting minutes of the hospital ethical committee.
- GAHAR surveyor may interview staff to inquire about the code of ethics.

Evidence of compliance:

1. The hospital has an ethical committee with terms of reference that addresses at least a) to f) in the intent.
2. Staff members are aware of the hospital ethical code.
3. The committee meets regularly, and the minutes of meetings are recorded.
4. Ethical issues are discussed and managed according to the approved code of ethics.
5. Addressed ethical issues are used for education and staff professional development.

Related standards:

PCC.02 Patient and family rights, CSS.15 Organ/Tissue transplantation WFM.10 Medical Staff Structure, WFM.07 Orientation Program, WFM.10 Medical Staff Structure, WFM.13 Medical Staff Performance Evaluation, WFM.14 Peer Review process, ATH.05 Patient rights during bedside teaching, ATH.06 Patient safety and clinical teaching, ATH.07 Activities of house officers and residents, ATH.09 Research Ethical Framework, ATH.10 Research Patient Rights

Ensuring staff well-being and health

OGM.16 The hospital ensures the availability of staff rest areas.

Effectiveness

Keywords:

Staff rest areas

Intent:

Staff rest areas, including spaces that are used solely by employees for hygiene needs, clothes change, rest, and eating when applicable, such as staff lounge and sleeping areas.

Providing a comfortable and ergonomically supportive setting for workers has become a priority to punch up staff productivity as well as recruitment and retention.

Staff rest areas should be ventilated, lit, and clean, not overcrowded, reachable through communication tools, and secure.

Survey process guide:

- GAHAR surveyor may observe staff resting areas to check the availability of communications means, security, and ventilation.

Evidence of compliance:

1. Staff rest areas are ventilated, lit, and clean.
2. Staff rest areas are not overcrowded.
3. Staff rest areas are reachable through communication tools.
4. Staff rest areas are secured and not readily accessible for non-staff members.
5. The staff has access to healthy food and water supply.

Related standards:

OGM.14 Staff Health, EFS.09 Security Plan, OGM.15 Ethical Management, OGM.04 Hospital Director, OGM.08 Hospital leaders , QPI.07 Managerial Performance Measures , WFM.01 Workforce Laws and regulations, EFS.01 Hospital environment and facility safety management

OGM.17 The hospital has an approved staff health program that is monitored and evaluated annually according to laws and regulations.

Safety

Keywords:

Staff Health program

Intent:

The hospital shall implement a staff health program to ensure the safety of the staff according to workplace exposures.

A pre-employment medical examination is required for all employees' categories to evaluate their appropriateness for safe performance, and staff that is exposed to certain hazards as radiation should have periodic specific medical evaluations (tests and examinations). A situational examination may be required in case of exposure to specific substances.

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 a hospital-wide risk assessment program that identifies high-risk areas and processes.

The program scope covers all staff and addresses 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 bloodborne and airborne pathogens and others
- e) Staff education on the risks within the hospital environment as well as on their specific job-related hazards.
- f) Staff preventive immunizations.
- g) Results of the medical evaluation are documented in staff health records, and action is taken when there is a positive result, including employee awareness of these results and provision of counseling and interventions as might be needed.
- 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 is 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 (eg., medical evaluation, immunization, work injuries) shall be documented and kept according to laws and regulations.

Survey process guide:

- GAHAR surveyor may interview staff members who are involved in developing and executing staff health programs to check program structure, risks, education, and orientation records.
- GAHAR surveyor may review a sample of staff health records to ensure standard compliance.

Evidence of compliance:

1. There is an approved hospital's staff health program according to local laws and regulations that cover a) through j) in the intent.
2. There is an occupational health risk assessment that defines occupational risks within the hospital.
3. Staff members are aware of the risks within the hospital environment, their specific job-related hazards, and periodic medical examinations.
4. All staff members are subject to the immunization program and work restrictions according to laws and regulations and approved hospital guidelines.
5. All test results, immunizations, post-exposure prophylaxis, and interventions are recorded in the staff's health record.
6. There is evidence that actions are taken, and employees are informed, in case of positive results.

Related standards:

EFS.07 Safety Management Plan, IPC.02 IPC program, risk assessment, guidelines, QPI.09 Risk Management Program, IPC.05 PPE, guidelines, Physical Barriers, IPC.08 Safe injection practices, WFM.01 Workforce Laws and regulations, DAS.23 laboratory safety program, DAS.09 Radiation Safety Program.

Community Assessment and Involvement

Chapter intent:

Community assessment and involvement are crucial aspects of healthcare delivery, particularly within hospitals. These processes enable healthcare institutions to tailor their services to the specific needs of the communities they serve, ensuring that care is accessible, equitable, and effective. Establishing a community involvement program is vital for hospitals to build strong relationships with the populations they serve. Such programs help identify community health needs, address service delivery gaps, and uncover collaboration opportunities. Developing and implementing a successful community involvement program involves identifying various stakeholders and community partners, including healthcare providers, patients and families, local government and public health agencies, non-profit organizations, and educational institutions. Hospitals can engage with the community through various communication channels, such as surveys, focus groups, community meetings, forums, social media, and websites.

A comprehensive community health assessment enables hospitals to design a scope of services that meets the specific health needs of the population. This involves collecting and analyzing data on disease prevalence, health behaviors, and social determinants of health within the community. Hospitals can further enhance their impact by participating in community health initiatives, such as public health campaigns like smoking cessation programs or community wellness events like health fairs and screenings. Regular evaluation of community involvement programs is essential to ensure they remain effective and responsive to evolving needs.

Promoting a culture of accreditation within the hospital and the broader community encourages a commitment to quality, safety, and continuous improvement. Accreditation processes require hospitals to regularly evaluate their practices, engage the community in feedback mechanisms, and ensure that their services adhere to established standards. During the GAHAR survey, surveyors will assess the efficiency of the hospital's community assessment and involvement program.

Chapter purpose:

- 1) Understand the Role of Community Assessment.
- 2) Identify Key Stakeholders and Partners.
- 3) Build Effective Communication Channels.
- 4) Promoting a Culture of Accreditation and Quality.

CAI chapter Summary of Changes*Summary of Changes Chapter 12*

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
CAI.01 KW: Community involvement program	CAI.02 KW: planning for community involvement	New standard
CAI.02 KW: Community partners and channels of communication		New standard
CAI.03 KW: Community Health Needs Assessment	CAI.02 KW: planning for community involvement	New standard
CAI.04 KW: Community involvement activities.	CAI.03 KW: Community Education	<p>7) Modified standard statement: (The hospital provides community involvement activities in cooperation with community partner(s)).</p> <p>8) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.01: The hospital provides community involvement activities in collaboration with community partners). • (EOC.02: Hospital leaders are aware of their specific community health needs and health educational needs). <p>9) Added a new EOC: (EOC.03: The performed community involvement activities meet the identified community health needs).</p>
CAI.05 KW: Community Initiatives	CAI.01 KW: Community Initiatives	1) Modified standard statement : (The hospital considers international, regional, or national, health initiatives to be engaged with the community and/or improve its services).

		2) Added new EOCs: (EOC.01 , EOC.02 , EOC.03 & EOC.04)
CAI.06 KW: Community Involvement program evaluation	CAI.04 KW: Community Involvement program evaluation	<p>4) Modified standard statement (Outcomes of the community health needs assessment and involvement program are evaluated).</p> <p>5) Added new EOCs:</p> <ul style="list-style-type: none"> • (EOC.01 The hospital reviews the community assessment and involvement program annually). • (EOC.04 The community needs and the related services are updated based on the evaluation).
CAI.07 KW Hospital advertisement	PCC.01 KW: Hospital advertisement	<p>4) Modified EOC: (EOC.01: The hospital has a process to provide clear, updated, and accurate advertisements of its services.)</p> <p>5) Rephrasing of EOC: (EOC.03 Community stakeholders receive clear, updated, and accurate information about the hospital's services, healthcare professionals, and working hours.)</p> <p>6) Added a new EOC: (EOC.04 Violations of advertisements or providing false information to the community are subjected to actions according to the hospital code of ethics).</p>
CAI.08 KW: Promoting accreditation and quality	CAI.06 KW: promoting quality of care	<p>4) Modified standard statement: (The hospital supports accreditation promotion to the community stakeholders and shares experience with other healthcare organizations).</p> <p>5) Added new EOCs: (EOC.01 , EOC.02 , EOC.03 & EOC.04)</p>

Effective community services

CAI.01 The hospital establishes a community involvement program.

Patient-centeredness

Keywords:

Community involvement program

Intent:

Healthcare organizations must support communities in shaping their own health by involving community members in hospital governance, including policy formulation, decision-making, and oversight. This is important for ensuring the relevance of services offered to the community.

A comprehensive community health needs assessment and involvement program should encompass various components to effectively identify, address, and involve the community in addressing health needs.

The hospital shall develop a community assessment and involvement program that addresses at least the following:

- a) Identification and description of the targeted population.
- b) Define the scope and objectives of the program.
- c) Identification of community partners
- d) Identify communication channels with community partners.
- e) Community needs assessment strategy.
- f) Community involvement activities, including health education.
- g) Collaborate with international, regional, and/or national community initiatives.
- h) Budget and resources.
- i) Evaluation of the program.

Survey process guide:

- GAHAR surveyor may review the community assessment and involvement program to ensure it is aligned with other initiatives, laws, and regulations.
- GAHAR surveyor may inquire about the community assessment program during the leadership interview session.
- GAHAR surveyor may interview staff to check their awareness of community initiatives.

Evidence of compliance:

1. The hospital has an approved program for community health needs assessment and involvement that covers all elements in the intent from a) through i).
2. There is a designated person (s) to oversee and coordinate the program.
3. Involved staff members are aware of the main components of the program.
4. The program is annually evaluated.

Related standards:

CAI.02 Community partners and channels of communication, CAI.03 Community Health Needs Assessment, CAI.04 Community involvement activities, CAI.06 Community Involvement program evaluation

CAI.02 The hospital identifies community partners and channels to communicate with them.

Effectiveness

Keywords:

Community partners and channels of communication

Intent:

Hospitals should ensure the availability of a transparent, visible, two-way communication process for their community to express their concerns and for the hospital to show an adequate and caring response. The hospital shall identify the key community partners and stakeholders that it will engage with, such as authorities (e.g., ministries, municipalities, civil defense...etc.) and business customers (e.g., corporate customers, insurance companies, suppliers...etc.), social and non-governmental organizations, media, schools, religious institutions, and other healthcare providers in the area.

The hospital shall determine the most effective communication channels and tools for reaching and engaging with community partners. This may include in-person meetings, newsletters, email updates, social media platforms, community events, webinars, etc.

The hospital should have a plan for managing communication during crises or emergencies that may impact the hospital or the community. Ensure that all stakeholders are aware of their roles and responsibilities in such situations.

Survey process guide:

- GAHAR surveyor may review the identified community partners and communication channels.
- GAHAR surveyor may inquire about communication with community stakeholders during leadership interview sessions.
- GAHAR surveyor may interview staff to check their awareness of the communication channels.

Evidence of compliance:

1. The hospital identifies the key community partners and stakeholders that the hospital will communicate and engage with.
2. The hospital identifies the proper communication channels with different community stakeholders.
3. The hospital communicates with community stakeholders.

Related standards:

CAI.01 Community involvement program, PCC.16 Complaints and suggestions , PCC.15 Patient and family feedback.

CAI.03 Community health needs are assessed in collaboration with community partner(s).

Patient-centeredness

Keywords:

Community Health Needs Assessment

Intent:

The availability of population information that is updated regularly as defined by the policy and when new data is available promotes evidence-based decisions and optimizes health program utilization.

Local population data may include demographics, health stand-up, and health determinants that should be regularly reviewed for better health planning, as data sources could be primary or secondary. 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. The hospital uses information collected from primary and/or secondary sources to understand the health needs of targeted populations and to decide which services to provide or update the package of services provided already.

The hospital assesses the community health needs that address at least the following:

- a) Identification and description of the targeted population.
- b) Health needs assessment should include at least the following:
 - i. Accessibility and timeliness of services.
 - ii. Community hazards assessment, including environmental problems.
 - iii. Unmet healthcare needs.
 - iv. Healthcare education needs.
 - v. Healthcare expectation.
- c) Planning to provide or update the package of services provided based on needs assessment.

Hospitals should align their services with community health needs. This process requires collaboration with specialized bodies that can define community health needs. This approach accomplishes the hospital's responsibility towards its community.

Survey process guide:

- GAHAR surveyor may review the community assessment and involvement program to check that it is aligned with other initiatives and with laws and regulations.
- GAHAR surveyor may inquire about the community health needs assessment during the leadership interview session.
- GAHAR surveyor may interview staff to check their awareness about the community health needs.

Evidence of compliance:

1. Community health needs assessment is done, including items from i) to v) as mentioned in the intent.
2. There is evidence that community health needs assessment is done in collaboration with the community.
3. The hospital shares information related to community health needs assessment with the governing body and community partners.
4. The hospital aligns the provided services with the assessed community health needs.

Related standards:

CAI.01 Community involvement program, CAI.04 Community involvement activities , CAI.06 Community Involvement program evaluation.

CAI.04 The hospital provides community involvement activities in cooperation with community partner(s).

Effectiveness

Keywords:

Community involvement activities.

Intent:

The hospital may decide to perform multiple activities to achieve a certain health improvement goal. These activities may be in the form of health, educational, cultural, recreational, outreach, or other activities. This may be performed in collaboration with nearby schools, factories, markets, malls, police stations, or other key community partners. The hospital may provide education to the community on different topics, as appropriate, such as smoking cessation, life cycle approach to nutrition, healthy lifestyle, sexual and reproductive health, and mental health, including depression and addiction.

Survey process guide:

- GAHAR surveyor may review the identified community partner organizations.
- GAHAR surveyor may inquire about the community involvement activities during the leadership interview session.
- GAHAR surveyors may review the evidence of community involvement activities conducted by the hospital.
- GAHAR surveyor may interview staff to check their awareness of community health needs and educational health needs.

Evidence of compliance:

1. The hospital provides community involvement activities in collaboration with community partners.
2. Hospital leaders are aware of their specific community health needs and health educational needs.
3. The performed community involvement activities meet the identified community health needs.

Related standards:

CAI.01 Community involvement programt, CAI.02 Community partners and channels of communication, CAI.03 Community Health Needs Assessment.

Alignment with healthcare eco-system changes

CAI.05 The hospital considers international, regional, or national health initiatives to be engaged with the community and/or improve its services.

Effectiveness

Keywords:

Community Initiatives

Intent:

Periodic initiatives to promote health or prevent diseases in the community could be called through international, regional, national, or local organizations, including WHO, EMRO, national health initiatives, etc.

Organizations have called for many examples of such initiatives, including the implementation of international baby-friendly initiatives through WHO in collaboration with UNICEF, the Global Polio Eradication Initiative (GPEI), and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

Examples of national initiatives include adopting Universal Health Insurance, screening and treatment of chronic diseases, screening for breast cancer, and many other examples in different countries. In Egypt, for example, presidential initiatives include 100 million Healthy Lives to sustain robust screening, care, and treatment services for people with HCV. It has resulted in testing over 60 million people and treating more than 4 million people. By doing so, Egypt reduced the incidence of new infections from 300 per 100 000 in 2014 to 9 per 100,000 in 2022.

All hospitals shall be alert for such initiatives and take the opportunity to share in promoting health and raising awareness of the community.

Survey process guide:

- GAHAR surveyor may review and check the engagement of the hospital in such initiatives.
- GAHAR surveyor may inquire about how the hospital tracks such initiatives and engages with such organizations during the leadership interview session.
- GAHAR surveyor may interview staff to check their awareness of community initiatives.

Evidence of compliance:

1. The hospital has defined channels to be notified of international, regional, and national initiatives.
2. The hospital makes use of the initiatives to promote health and raise awareness in the community.
3. The hospital collects information about community health through sharing in such initiatives.
4. The hospital uses the information in planning for the services provided to the community.

Related standards:

CAI.01 Community involvement program, OGM.06 Strategic Planning

CAI.06 Outcomes of the community health needs assessment and involvement program are evaluated.

Effectiveness

Keywords:

Community Involvement program evaluation

Intent:

Evaluation of the community needs assessment and involvement program is important to assess whether the program has achieved its intended goals and had a positive impact on the community's health and well-being.

Hospitals may evaluate the community involvement program as follows:

- Annual review of the program, including:
 - Comparing the actual outcomes with the predefined program objectives.
 - Reviewing the conducted activities against the planned activities.
 - Effectiveness of interventions. (e.g., number of patients discovered with chronic diseases, number of patients referred to a nutritionist, number of patients referred to chest clinic to quit smoking... etc.)
- Community satisfaction with provided social activities is measured. (e.g., net promoter scoring for conducted activities or customer satisfaction survey)

- Reassessment of community needs every two years.

Survey process guide:

- GAHAR surveyor may review the community assessment and involvement program to check that it measures its outcomes.
- GAHAR surveyor may inquire about community assessment and involvement plan during the leadership interview session.
- GAHAR surveyor may interview staff to check their awareness of community initiatives.

Evidence of compliance:

1. The hospital reviews the community assessment and involvement program annually.
2. The hospital evaluates the community health needs every two years.
3. The hospital measures community satisfaction with the provided community activities.
4. The community needs, and the related services are updated based on the evaluation.

Related standards:

CAI.01 Community involvement program, CAI.03 Community Health Needs Assessment, PCC.15 Patient and family feedback, CAI.04 Community involvement activities.

Promotion to the community stakeholders

CAI.07 The hospital administration promotes the hospital and advertises the services to the community according to laws and regulations.

Effectiveness

Keywords:

Hospital advertisement

Intent:

Usually, hospitals use advertisements as an important tool to improve service utilization. Good advertisements help the community better understand the available health services.

Hospitals might advertise provided services through newspapers, TV advertisements, banners, brochures, pamphlets, websites, social media pages, call centers, SMS messaging, mass emailing, or other media.

Advertisements for healthcare services should be done honestly. Medical syndicates, nursing syndicates, pharmacist syndicates, and others address honesty and transparency as high values in their codes of ethics. The hospital can start complying with this standard by exploring the relevant laws, regulations, and ethical codes and finding out how they apply to the hospital advertisement/communication plan. The information must be accurate, updated, and clearly communicated about types of services, healthcare professionals, cost of services, and working hours.

Survey process guide:

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

Evidence of compliance:

1. The hospital has a process to provide clear, updated, and accurate advertisements of its services.
2. Advertisements are done in compliance with applicable laws, regulations, and ethical codes of local healthcare professionals' syndicates.
3. Community stakeholders receive clear, updated, and accurate information about the hospital's services, healthcare professionals, and working hours.
4. Violations of advertisements or providing false information to the community are subjected to actions according to the hospital code of ethics.

Related standards:

OGM.15 Ethical Management, ACT.01 Granting access (before patient's registration)

CAI.08 The hospital supports accreditation promotion to the community stakeholders and shares experience with other healthcare organizations.

Effectiveness

Keywords:

Promoting accreditation and quality

Intent:

Being accredited is one of the most important achievements for any hospital. Accreditation is official proof that the hospital is meeting the standards of quality of care, which results in increased trust in the hospital's services from community stakeholders.

Accredited hospitals carry a social responsibility towards their communities to raise awareness of the quality of care, as hospitals shall be a model in providing excellent quality of care through proper implementation of accreditation standards, which push other hospitals to raise the bar of the quality of services provided to the community.

The hospital shall conduct awareness sessions as a part of its social corporate responsibility to the different stakeholders in the community (e.g., awareness session to non-accredited hospitals about the benefits of accreditation and how it impacts the quality of services provided or inviting teams from non-accredited hospitals for grand tours in the hospital to check the quality of services).

The hospital could gain many benefits from accreditation, including improving the quality indicators, patient experience, and patient journey in the hospital... etc. The hospital shall share those benefits with other hospitals to encourage them to go through the accreditation process.

Survey process guide:

- GAHAR surveyor may review hospital activities regarding promoting its accreditation to the community stakeholders.

Evidence of compliance:

1. The hospital has a process to support promoting accreditation to the community stakeholders.
2. The hospital conduct awareness activity about the benefits of accreditation to the community stakeholders
3. The hospital shares its accreditation journey and relevant success stories with the community stakeholders.
4. The hospital cooperates with other hospitals seeking accreditation upon their request.

Related standards:

OGM.04 Hospital director, OGM.08 Hospital leaders, QPI.03 Quality management Team

Workforce Management

Chapter intent:

To fulfill its mission and meet patient needs, the hospital requires a diverse range of skilled and qualified personnel. The hospital workforce includes all the staff members within the facility. Effective workforce planning, which includes determining the appropriate number and skill mix of employees, is crucial. Developing clear job descriptions, comprehensive orientation programs, and robust training initiatives is essential to support staff in providing quality healthcare. A well-organized hospital must have a clearly defined structure for its medical staff, including distinct departments, divisions, and medical committees. This chapter outlines the roles and responsibilities of medical staff leaders in areas such as credentialing, privileging, bylaws development, committee and department management, and performance improvement.

Ensuring the medical staff's credentials and competencies through ongoing education and certification processes is crucial for maintaining high standards of care. Additionally, hospitals must provide opportunities for professional development and support the well-being of their staff, as they represent a significant investment and are essential to the hospital's success.

Globally, a shortage of healthcare professionals is evident in many regions. In some countries, professional licenses are renewable, requiring physicians, nurses, and other healthcare workers to periodically undergo a renewal process to demonstrate their competence and ongoing development. National bodies overseeing medical and nursing education are established in various countries. There is an increasing trend towards national performance evaluation and ranking of healthcare professionals, with many healthcare systems adopting the pay-for-performance model.

GAHAR surveyors shall review the implementation of laws and regulations, medical bylaws, nursing bylaws, policies, procedures, and plans reflecting the processes of the human resources department through interviews with leadership and staff and review of different healthcare professionals' staff files.

Chapter purpose:

The main objective is to ensure hospitals maintain an effective Workforce Management program. The chapter addresses the following objectives:

- 1) Efficient workforce planning.
- 2) Effective orientation, continuous medical education, and training program.
- 3) An efficient mix of staff.
- 4) Periodic evaluation of staff performance.

WFM Chapter Summary of Changes*Summary of Changes Chapter 13*

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
WFM.01 KW: Workforce Laws and regulations	WFM.01 KW: Workforce Laws and regulations	<ol style="list-style-type: none"> Added new EOCs: <ul style="list-style-type: none"> (EOC.01 There is qualified staff to manage and develop workforce). (EOC.02 The hospital identifies all applicable laws, regulations and norms that guide workforce management). (EOC.03 Responsible staff members are aware of laws, regulations and norms that guide workforce management). Modified EOC: (EOC.04 Workforce is managed and developed according to applicable laws and regulations and norms that guide workforce management).
WFM.02 KW: Staffing Plan	WFM.02 KW: Staffing Plan	<ol style="list-style-type: none"> Rephrasing of standard statement to be: (The hospital develops a staffing plan to ensure that the provided services are consistent with patient needs, hospital mission, and professional practice recommendations).
WFM.03 KW: Recruitment process	WFM.03 KW: Recruitment	<ol style="list-style-type: none"> Rephrasing of standard statement to be: (The hospital implements a uniform recruitment process).
WFM.04 KW: Job Description	WFM.04 KW: Job Description	<ol style="list-style-type: none"> Rephrasing EOCs: <ul style="list-style-type: none"> (EOC.02: Job descriptions address each position's responsibilities, required qualifications, and reporting structure). (EOC.04 The job description is signed by the staff and kept in the staff's file). Modified EOC (EOC.03 On assignment, the job description is discussed with staff members, including independent practitioners).
WFM.05 KW: Verifying credentials	WFM.05 KW: Verifying credentials	<ol style="list-style-type: none"> Rephrasing of standard statement to be: (Staff credentials are collected, evaluated, and verified). Rephrasing of EOCs: (EOC.01 & EOC.03) Added a new EOC: (EOC.04 Credible efforts are utilized for the verification from the primary sources either directly or through a third party).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
WFM.06 KW: Staff Files	WFM.06 KW: Staff Files	<p>1) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.04: Staff files include all the required records from i) through vii), as mentioned in the intent). • (EOC.05: Former staff files are retained for a specific time as per hospital policy and the hospital maintain confidentiality during disposal of files).
WFM.07 KW Orientation Program	WFM.07 KW: Orientation Program	<p>1) Modified EOCs: (EOC.01, EOC.02 & EOC.03).</p> <p>2) Rephrasing (EOC.05: There is evidence that each staff member has completed the orientation program which is recorded in their file).</p> <p>3) Rephrasing of EOC: (EOC.04: All New staff members, including contracted and outsourced staff, attend the orientation program regardless of employment terms).</p>
WFM.08 KW Continuous Education Program	WFM.08 KW: Continuous Education Program	<p>1) Rephrasing of EOC: (EOC.03 The educational program is based on the training needs assessment of the staff).</p> <p>2) Added a new EOC: (EOC.04 Department heads approve the departmental education activities necessary to maintain departmental care delivery).</p>
WFM.09 KW: Staff Performance Evaluation	WFM.09 KW: Staff Performance Evaluation WFM.04 KW: Job Description	<p>1) Modified EOCs:</p> <ul style="list-style-type: none"> • (EOC.02: The employee's department carries out performance and competency evaluations). • (EOC.03: Performance and competency evaluation is based on the job description),
WFM.10 KW: Medical Staff Structure	WFM.10 KW: Medical Staff Structure WFM.11 KW: Medical Staff bylaws	14) Updated standard (WFM.10) by merging two standards (WFM.10. & WFM.11) in Hospital edition 2021.

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
WFM.11 KW: Medical Staff Appointment	WFM.12 KW: Medical Staff Appointment	<p>4) Updated EOC (EOC.02) by merging two EOCs (EOC.02& EOC.04) in Hospital edition 2021.</p> <p>5) Added a new EOC: (EOC.04: The appointment decisions and recommendations are approved by a relevant council/committee and/or by the medical director).</p>
WFM.12 KW: Clinical Privileges	WFM.13 KW: Clinical Privileges	<p>1. Modified EOCs:</p> <ul style="list-style-type: none"> • EOC.01: The hospital has an approved policy that addresses at least all elements from a) through g) in the intent.
WFM.13 KW: Medical Staff Performance Evaluation	WFM.14 KW: Medical Staff Performance Evaluation	<p>1) Added new EOCs:</p> <ul style="list-style-type: none"> • EOC.01: Ongoing professional practice evaluation (OPPE) of the medical staff is performed at least annually. • EOC.05: The results will be used to help decisions related to re-privileging and re-credentialing and reappointment. <p>2) Modified EOC:</p> <ul style="list-style-type: none"> • EOC.03: The evaluation utilizes objective data to measure achievement in clinical care provision, clinical outcome, and attitude and behavior.
WFM.14 KW: Peer Review process.	WFM.15 KW: Peer Review	<p>1. Added new EOC: (EOC.04: The results of the peer review are confidentially communicated to the concerned staff and to the medical director to take corrective actions and improve performance).</p>
WFM.15 KW: Nursing laws and regulations	<p>WFM.16 KW: Nursing laws and regulations</p> <p>WFM.17 KW: Nursing structure</p>	<p>1) Updated standard (WFM.15) by merging two standards (WFM.16 & WFM.17) in Hospital edition 2021.</p>
WFM.16 KW: Other healthcare	WFM.18 KW: Other health care practitioners' job	<p>Rephrasing of standard statement to be: (Legal requirements governing the professional</p>

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
practitioners' job responsibilities	responsibilities	regulation of other healthcare practitioners are followed).
WFM.17 KW: Working Hours	WFM.19 KW: Working Hours	No change.

Efficient workforce planning

WFM.01 Workforce recruitment, education, training, and appraisal processes comply with laws and regulations.

Efficiency

Keywords:

Workforce Laws and Regulations

Intent:

Labor laws and regulations mediate the relationship between workers, hospitals, syndicates, and the government. The hospital 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 hospital 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 is qualified staff to manage and develop the workforce.
2. The hospital 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.03 Recruitment process, WFM.07 Orientation Program, WFM.08 Continuous Education Program, WFM.13 Medical Staff Performance Evaluation

WFM.02 The hospital develops a staffing plan to ensure that the provided services are consistent with patient needs, hospital mission, and professional practice recommendations.

Efficiency

Keywords:

Staffing Plan

Intent:

Staff planning is the process of ensuring that a hospital has the right people to carry out the work needed for business successfully by matching detailed staff data, including skills, potential, aspirations, and location, with business plans.

The shortage of competent healthcare professionals in multiple areas is an alarming sign, especially in critical care disciplines such as intensive care units and anesthesia.

The hospital must comply with laws, regulations, and recommendations of professional practices that define desired education levels, skills, or other requirements of individual staff members, including independent practitioners, or that define staffing numbers or a mix of staff for the hospital. The staffing plan is reviewed on a regular basis and updated as necessary by the leaders of each clinical or managerial area, who define the individual requirements of each staff position. The hospital maintains a safe level of staff members, including independent practitioners' numbers and skill level, that matches at least 60% of its requirements, especially in critical care areas.

Leaders consider the following factors to project staffing needs:

- a) The hospital mission, strategic, and operational plans.
- b) Complexity and severity mix of patients served by the hospital.
- c) Services provided by the hospital.
- d) Workload during working hours and different shifts.
- e) Technology and equipment used in patient care.

Survey process guide:

- GAHAR surveyor may review the hospital staffing plan, observe workforce allocation and skills, or review staff files, including independent practitioners, to check compliance of the staffing plan to laws, regulations, and professional practices recommendations.

Evidence of compliance:

1. The staffing plan matches the mission, strategic, and operational plans.
2. Staffing plan complies with laws, regulations, and recommendations of professional practices.
3. The staffing plan identifies the estimated needed staff numbers, including independent practitioners, skills, and qualifications required to meet the hospital's specific needs.
4. The staffing plan is monitored and reviewed at least annually.

Related standards:

OGM.02 Mission Statement, OGM.06 Strategic Planning, OGM.07 Operational Planning, OGM.08 Hospital leaders

WFM.03 The hospital 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 hospital 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 hospital for similar types of staff.

The hospital 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 hospital policy.
- GAHAR surveyor may interview staff members involved in the recruitment process to assess the process.

Evidence of compliance:

1. The hospital 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 hospital policy.
3. The recruitment process is uniform across the hospital for similar types of jobs.
4. The hospital leaders participate in the recruitment process.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.02 Staffing Plan, OGM.08 Hospital leaders

WFM.04 Job descriptions address each position's requirements and responsibilities.

Effectiveness

Keywords:

Job Description

Intent:

The job description is a broad, general, and written statement of a specific job based on the findings of a job analysis and complies with rules and regulations.

It generally includes duties, purpose, responsibilities, scope, and working conditions of a job. In the hospital, a job description is required to ensure that staff, including independent practitioner's requirements and responsibilities, align with the hospital's mission.

It allows leaders to make informed staff assignments, recruitment, and evaluation. It also enables staff members to understand their responsibilities and accountabilities; in general, job descriptions are used for the following:

- I. Addressing the qualifications required to hire, transfer, and promote staff for each position.
- II. Addressing the duties and responsibilities used for job-specific orientation for newly hired employees.
- III. The staff annual performance evaluation will be linked to the duties and responsibilities in the job descriptions.

The hospital starts by building a job description template that includes a description of the job. The hospital ensures that the results of the staff planning process, such as the skill mix, are aligned with the job requirements mentioned in the job description.

Job descriptions are required for all clinical, non-clinical, full-time, and part-time staff, temporary staff, and those under training. However, physicians' duties and responsibilities for clinical performance may

be available in their clinical privileges. Physicians in managerial positions require job descriptions for their administrative roles.

Survey process guide:

- GAHAR surveyor may review a sample of staff files of different positions to check for the signed job description.
- GAHAR surveyor may interview staff to check their awareness of their job description.

Evidence of compliance:

1. There is a 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:

OGM.08 Hospital leaders, OGM.09 Departmental management, WFM.06 Staff Files, WFM.07 Orientation Program, WFM.09 Staff Performance Evaluation,

WFM.05 Staff credentials are collected, evaluated, and verified.

Safety

Keywords:

Verifying credentials

Intent:

Credentials are documents 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, or a license to practice.

Staff credentials must be evaluated before recruitment to ensure that they match the requirements of the needed position and qualifications required for the job responsibilities; through comparing the candidate's credentials with the qualifications and experience mentioned in the job description of such position, the evaluation needs to be documented in the staff files.

Some of these documents are required by law and regulations and need to be verified by the original source that issued the document. Primary source verification is required through contact with the original source either directly or through letters, emails, telephone calls, fax, website, or a similar method. Credible effort is required to complete the primary source verification through at least three different attempts within 90 days. Verification through a third party is acceptable if the third party uses an acceptable verification method.

When staff members, including independent practitioners, are hired by the hospital, the process of verifying credentials and evaluating the qualifications that match the position requirements with the qualifications of the prospective staff member must be done.

Survey process guide:

- GAHAR surveyor may review the credential verification process.

- GAHAR surveyor may review a sample of staff members (including independent practitioners) files to check the availability of required credentials for each position.
- GAHAR surveyor may interview staff members involved in the credentialing process to check their awareness of the process.

Evidence of compliance:

1. Required credentials for each position are collected and kept in staff files, including independent practitioners' files.
2. There is a process for evaluating and verification of the credentials in the hospital.
3. Primary source verification is uniformly applied for all required credentials.
4. Credible efforts are utilized for the verification from the primary sources either directly or through a third party.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.06 Staff Files

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 hospital 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 hospital 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 hospital policy.

Staff files, including independent practitioners, may contain sensitive information that must be kept confidential.

The hospital 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 hospital and professional education received.
- vii Copies of provisional and annual performance evaluations.
- c) Update of file contents.
- d) Storage.
- e) Retention time.
- f) Disposal.

Survey process guide:

- GAHAR surveyor may review the hospital 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 hospital has an approved policy to maintain and standardize 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 hospital policy, and the hospital maintains confidentiality during the disposal of files.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.04 TJob Description, WFM.05 Verifying 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:

Regardless of employment experience, any new staff member needs to understand the entire hospital structure and how their specific clinical or nonclinical responsibilities contribute to the hospital's mission.

This is accomplished through a general orientation to the hospital and their role and a specific orientation to the job responsibilities of their position. Staff orientation, especially when first employed, with the hospital policies, ensures alignment between the hospital mission and staff activities. It also helps to

create a healthy hospital culture where all staff work with a shared mental model and towards agreed-upon objectives. Staff orientation also facilitates the integration of new staff with the already available to form effective teams that offer safe and quality care rapidly.

The hospital 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.

The general orientation program addresses at least the following:

- a) The hospital mission, vision, values, and hospital structure.
- b) Hospital policies for Environmental and Facility Safety.
- c) General information about infection control policies and procedures.
- d) Hospital policies for performance improvement, patient safety, and risk management.
- e) Ethical framework and code of conduct.
- f) Patient and family rights.

The department orientation program addresses at least the following:

- g) Review of relevant policies and procedures.
- h) Operational processes.
- i) Work relations.

The job-specific orientation program addresses at least the following:

- j) Job-specific duties and responsibilities as per the job description.
- k) Technology and equipment use.
- l) High-risk processes.
- m) Staff safety and health.

The hospital is encouraged to develop a staff manual that describes the processes of staff appointment and reappointment, appraisal, complaint management, satisfaction measurement, code of ethics, disciplinary actions, and termination.

Survey process guide:

- GAHAR surveyor may interview some staff members and inquire about the orientation process.
- 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. A general orientation program is performed, and it includes at least the elements from a) through f).
2. A department orientation program is performed, and it includes at least the elements from g) through i).
3. A job-specific orientation program is performed, and it includes at least the elements from j) through m).
4. All New staff members, including contracted and outsourced staff, attend the orientation program regardless of employment terms.
5. There is evidence that each staff member has completed the orientation program, which is recorded in their file.

Related standards:

WFM.04 Job Description, WFM.08 Continuous Education Program, IPC.04 Hand Hygiene, IPC.05 PPE, guidelines, Physical Barriers, IPC.08 Safe injection practices, EFS.03 Fire and smoke safety ,

EFS.06 Hazardous materials safety and waste management, EFS.07 Safety Management Plan., EFS.13 Disaster Plan, QPI.01 Quality management plan, QPI.09 Risk Management Program, OGM.15 Ethical Management, OGM.02 Mission Statement PPC.02 Patient and family rights.

Effective training and education

WFM.08 A continuous education and training program is developed and implemented.

Effectiveness

Keywords:

Continuous Education Program

Intent:

For any hospital 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, especially if they are designed to satisfy staff needs necessary to deliver the hospital's mission.

The program is designed in a flexible manner that satisfies all staff categories based on services provided, needs assessment, new information, and tailored training plans and delivery.

Evidence-based medical and nursing practice guidelines and other resources are accessible 24 hours to all staff.

The hospital ensures that education and training are provided and recorded according to the staff member's relevant job responsibilities and based on training needs assessment, which 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 hospital.
- h) Basic cardiopulmonary resuscitation training at least every two years for all staff that provide 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, and 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 review the hospital's continuous education and training program.
- GAHAR surveyor may check a sample of staff files to assess for evidence of attendance in the education and training program.

Evidence of compliance:

1. There is a continuous education and training program for all staff categories that may include elements in the intent from a) through m).
2. Resources (human and non-human) are 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.04 Job Description, WFM.09 Staff Performance Evaluation, PCC.02 Patient and family rights, ICD.06 Medical patient assessments, ICD.16 Clinical practice guidelines adaptation and adoption, CSS.06 Cardiopulmonary resuscitation and medical emergencies, EFS.07 Safety Management Plan, QPI.01 Quality management plan, QPI.09 Risk Management Program, IPC.01 IPC program, risk assessment, guidelines.

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. The hospital uses a performance evaluation tool to ensure staff have the required criteria for doing jobs and achieving objectives. Performance evaluation also promotes communication between employees and leaders, enabling them to make informed decisions about staff planning, selection, incentives, training and education, and career planning.

Competency is the process of determining the ability of staff to fulfill the primary responsibilities of the position for which a patient was hired. Observing and measuring competency for every position in the hospital is one of the most important duties of the department leaders. They must also ensure that each staff member understands the expectations, responsibilities, activities, and competencies required for their 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 services, POCT services, and staff who are handling critical medical equipment).

The hospital should have a documented process for employees' performance evaluation, including performance review methods, tools, evaluation dimensions, criteria, time interval, appeal process, and responsible person for each staff category, and the effective management of underperformance.

Survey process guide:

- GAHAR surveyor may interview department/service or hospital leaders and inquire about used tools for staff performance evaluation.

- GAHAR surveyor may check a sample of staff files to assess completion of performance evaluations.

Evidence of compliance:

1. Performance and competency evaluation is performed at least annually for each staff member.
2. The employee's department carries out performance and competency evaluations.
3. Performance and competency evaluation is based on the job description.
4. There is evidence of employee feedback on performance and competency evaluation.
5. Actions are taken based on a performance review.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.04 Job Description, WFM.08 Continuous Education Program, WFM.12 Clinical Privileges , OGM.08 Hospital leaders.

Efficient medical staff structure

WFM.10 An organized medical staff structure is developed to oversee the 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.

Thus, the term medical staff includes all physicians, dentists, and other professionals permitted to treat patients with partial or full independence, regardless of their relationship to the hospital.

The hospital defines those other practitioners, such as house officers and junior doctors, who are no longer in training but may or may not be permitted by the hospital to practice independently. Those medical staff have a diagram describing the line of authority within the hospital.

"Medical staff bylaws" refer to a set of rules and regulations established by a hospital or healthcare institution that govern the activities, conduct, and responsibilities of the medical staff. These bylaws outline criteria for granting and maintaining privileges, as well as procedures for peer review, credentialing, and other important aspects of healthcare delivery within the institution.

Medical Staff Bylaws may address the following points:

- a) Entire medical staff structure.
- b) Medical staff committee structure and function.
- c) Medical staff categories and the specific qualifications necessary for each category (consultant, registrar, resident, etc.)
- d) Roles and responsibilities of each staff category, including employment status (full-time, part-time, locum, visitor, etc.)
- e) Credentialing, re-credentialing, appointment, and re-appointment processes, including primary source verification as applicable.
- f) The privileging and re-privileging (application, granting, revision, renewal), including temporary and emergency privileges.

- g) Ethics of good medical practice and conflict of interest.
- h) Defined criteria and process for suspension and other disciplinary actions, including the mechanism for a fair hearing and appeal process.
- i) Defined criteria and process for peer review

Survey process guide:

- GAHAR surveyor may review a document describing the medical staff structure and medical staff bylaws.
- GAHAR surveyor may interview staff members to check their awareness of the medical staff structure and medical staff bylaws.

Evidence of compliance:

1. The hospital has a medical staff structure that is developed according to the hospital's mission, scope of services, and recommendations of professional practices to meet patient needs.
2. The hospital develops medical staff bylaws that define the structure and responsibilities of the medical staff within the hospital as described in the intent from a) through i).
3. The medical staff bylaws follow applicable laws, regulations, and professional practice recommendations.
4. Medical staff structure and medical staff bylaws are approved by the governing body.

Related standards:

WFM.01 Workforce laws and regulations; WFM.02 Staffing plan, OGM.01 Governing body Structure and responsibilities,

WFM.11 Appointment of medical staff members is performed according to applicable laws and regulations and approved medical staff bylaws.

Safety

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 the patient care services that the hospital patients need and that the hospital can support with qualified staff and technical capabilities.

For initial applicants, the information reviewed is primarily from outside sources.

The hospital policy identifies the individuals or mechanisms accountable for this review, any criteria for making decisions, and how decisions will be documented. The policy also specifies the process of appointing independent practitioners for emergency needs or a temporary period.

Survey process guide:

- GAHAR surveyor may check a sample of staff files to assess whether the medical staff appointment process is aligned with the hospital's medical staff bylaws, laws, and regulations.
- GAHAR surveyor may interview staff members involved in the appointment process to check their awareness of the medical staff appointment 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 hospital medical staff bylaws, laws, and regulations.
3. Medical staff appointments are consistent with the hospital's mission and services.
4. The appointment decisions and recommendations are approved by a relevant council/committee and/or by the medical director.

Related standards:

WFM.01 Workforce laws and regulations, OGM.04 Hospital Director, OGM.02 Mission statement, WFM.05 Verifying credentials.

WFM.12 Medical staff members have current and specific delineated clinical privileges approved by the medical staff committee.

Safety

Keywords:

Clinical Privileges

Intent:

Clinical privilege refers to the specific authorization or permission granted to a healthcare provider, typically a physician or other licensed healthcare practitioner, by a healthcare institution or medical facility. These privileges allow the provider to perform specific clinical activities, procedures, or services within that institution.

Clinical privileges are essential in maintaining the quality and safety of patient care by ensuring that healthcare providers are qualified and competent in their respective specialties or areas of practice. The process of granting clinical privileges involves a thorough evaluation of the healthcare provider's education, training, experience, and credentials. It also considers the provider's demonstrated ability to perform specific clinical tasks safely and effectively.

The granting of clinical privileges is typically governed by medical staff bylaws, hospital policies, and regulatory bodies to ensure that only qualified individuals are permitted to provide patient care within the healthcare facility.

Clinical privileges are specific to the healthcare institution or facility where they are granted and may vary from one institution to another based on the institution's needs, the provider's qualifications, and the services offered. Providers are required to adhere to the scope of their granted clinical privileges and must undergo periodic re-evaluation to maintain or update these privileges as their skills and qualifications evolve.

Clinical privileges may also be granted in certain circumstances, such as the following:

- Temporary privilege refers to the provisional authorization granted to a healthcare provider to practice in a specific healthcare facility for a limited period not exceeding 90 days, for example, during the probationary period after employment.
- Emergency privilege is the immediate, time-limited authorization given to a healthcare provider to deliver essential care during an urgent situation when immediate medical attention is required. It is granted for a very short duration of an emergency and is valid only until the immediate crisis is over.
- Disaster privilege involves granting healthcare providers temporary authorization to practice during a declared disaster or public health emergency to assist in managing the surge of

patients and ensuring adequate care delivery. This authorization is valid until the emergency period concludes.

The hospital shall develop and implement a policy guiding clinical privileges delineation. The policy addresses the following:

- a) Medical staff members and independent practitioners with clinical privileges are consistent with the medical staff bylaws.
- b) Privileges indicate whether medical staff can admit, consult, and treat patients.
- c) Privileges define the scope of patient care services and the types of procedures they may provide in the hospital.
- d) Privileges are determined based on documented evidence of competency (experience, qualifications, certifications, skills) that is 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:

- GAHAR surveyor may review the clinical privileges delineation policy.
- GAHAR surveyor may interview medical staff to check their awareness of the clinical privilege delineation policy.
- GAHAR surveyor may review medical staff files to check for the recording of clinical privilege.

Evidence of compliance:

1. The hospital 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 delineation of clinical privileges.
3. Physicians' and dentists' files contain personalized recorded clinical privileges, including renewal when applicable.
4. Clinical privileges are accessible to and used by staff involved in booking surgery/invasive procedures.
5. Physicians and dentists comply with their clinical privileges.

Related standards:

WFM.04 Job Description, WFM.01 Workforce Laws and regulations, WFM.10 Medical Staff Structure, WFM.13 Medical Staff Performance Evaluation, WFM.09 Staff Performance Evaluation.

WFM.13 Performance of each medical staff member is reviewed and recorded at least annually.

Efficiency

Keywords:

Medical Staff Performance Evaluation

Intent:

Evaluation of medical staff performance over their professional careers ensures quality and safe patient care and determines continued competence to provide patient care services. It also helps healthcare

professionals develop their knowledge, skills, and attitudes (competencies) in a manner that fulfills their needs and ensures the sustainability of hospital services.

Ongoing professional practice evaluation (OPPE) for medical staff involves a continuous and systematic assessment of the clinical performance, competence, compliance with standards, and overall professional conduct used at the time of re-privileging.

The availability of agreed-upon criteria for performance evaluation ensures process uniformity and relevance of assessment towards the hospital mission and healthcare professional efficiency. Performance evaluation criteria include those related to the patient's medical record documentation and medication and may include:

1. Clinical care provision such as
 - a) Compliance with evidence-based protocols for specific conditions or procedures.
 - b) Completeness and timeliness of medical records documentation.
 - c) Appropriate use of resources, e.g., medication use, blood and blood products, antibiotic usage, etc.
 - d) Appropriateness of patient admissions.
2. Clinical outcomes such as:
 - a) Rates of mortality and morbidity.
 - b) Adverse events and procedure complication rate.
 - c) Discrepancies between pre- and post-operative diagnoses.
 - d) Sentinel events.
3. Attitude and behavior such as:
 - a) Incidents related to ethical conduct.
 - b) Disciplinary actions.
 - c) Attendance pattern and absenteeism.
 - d) Patient complaints.
 - e) Staff Complaints.

Survey process guide:

- GAHAR surveyor may interview medical staff members and inquire about performance evaluation.
- GAHAR surveyor may check a sample of medical staff files to review the evaluation criteria.

Evidence of compliance:

1. Ongoing professional practice evaluation (OPPE) of the medical staff is performed at least annually.
2. Medical staff members are aware of performance evaluation criteria.
3. The evaluation utilizes objective data to measure achievement in clinical care provision, clinical outcome, and attitude and behavior.
4. Performance evaluation results are used to improve individual medical performance.
5. The results will be used to help decisions related to re-privileging, re-credentialing, and reappointment.

Related standards:

WFM.09 Staff Performance Evaluation, WFM.04 Job Description, WFM.08 Continuous Education Program, WFM.12 Clinical Privileges, WFM.01 Workforce Laws and regulations , QPI.02 Performance Measures.

WFM.14 The hospital develops a peer review process.

Effectiveness

Keywords:

Peer Review process.

Intent:

Peer review is an activity that involves case evaluation by an unbiased internal or external practitioner to measure, assess, and improve professional practice and the quality of patient care.

The results of peer review activities are used to identify opportunities for improving patient care, improving clinical judgment and technical skill, and, as necessary, for implementing corrective action. The hospital may also conduct peer review as part of the credentialing process when granting or renewing clinical privileges for healthcare providers.

Criteria for referring clinical cases for internal and external peer review in healthcare organizations can vary based on the specific goals and policies of the organization. However, here are some common criteria that may be used:

- Internal peer review criteria
 - Adverse event or unexpected complication,
 - Significant variation from clinical guidelines/protocols/ best practices,
 - Unusual or rare cases,
 - When a pattern of similar issues or complications arises within a specific department or service.
- External peer review criteria
 - Complex or controversial cases,
 - Cases with legal or ethical implications,
 - Cases where a second opinion is deemed necessary by the patient or healthcare provider,
 - When a case requires expertise beyond what is available within the hospital,
 - Cases where there may be perceived or actual conflicts of interest within the organization.

The hospital shall develop and implement a policy and procedures for the peer review process that addresses at least the following:

- a) Defined criteria for referring clinical cases for internal peer review.
- b) Defined criteria for referring clinical cases for external peer review.
- c) The data or information from peer review is used for re-appointment and re-privileging.

Survey process guide:

- GAHAR surveyor may review the hospital policy for the peer review process.
- GAHAR surveyor may interview medical staff members to check their awareness of the policy.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements from a) through c) in the intent.
2. Medical staff members are aware of the peer review processes.
3. Peer review processes are implemented.
4. The results of the peer review are confidentially communicated to the concerned staff and to the medical director to take corrective actions and improve performance.
5. Results/reports of peer review are used for reappointment and re-privileging.

Related standards:

WFM.13 Medical Staff Performance Evaluation, WFM.12 Clinical Privileges.

Organized nursing structure

WFM.15 Legal requirements governing the professional regulation of nurses are followed.

Effectiveness

Keywords:

Nursing laws and regulations

Intent:

The hospital needs to ensure that it has qualified nursing staff that appropriately matches its mission, resources, and patient needs. The nursing staff is responsible for providing direct patient care, and nursing care contributes to overall patient outcomes.

Standards of nursing practice provide and outline the expectations of nurses' professional roles, 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 safe and effective nursing practice.

The nursing department is managed by a qualified nursing director with suitable education, training, and experience. The nursing director's 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 hospital and attending the senior leadership staff meetings
- d) Ensuring that schedules and assigned tasks to the staff are completed.

The hospital ensures that each nurse is qualified to provide safe and effective patient care and treatment by understanding the applicable laws and regulations that apply to nurses and nursing practice. The hospital defines trainee nurses and the duration of their training. Trainee nurses practice under supervision, and their performance is monitored and evaluated.

The hospital ensures that legal requirements governing the professional regulation of nurses and other healthcare professionals are followed.

Survey process guide:

- GAHAR surveyor may review the nursing director's job description.
- GAHAR surveyor may review the nursing director's file to check for licensure, qualification, and expertise.
- GAHAR surveyor may interview trainee nurses to check their awareness of their job description.
- GAHAR surveyor may observe the implementation of the nursing standards of practice.

Evidence of compliance:

1. The nursing director is qualified and has approved job description outlines responsibilities from a) to d) in the intent.
2. The process of appointing nursing staff is consistent with laws and regulations, and corrective actions are taken when a violation is identified.
3. Nurses not fully employed by the hospital follow the same credentialing process.
4. Nursing standards of practice are adopted and educated.

5. Nursing standards of practice are implemented.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.02 Staffing Plan, WFM.04 Job Description, WFM.05 Verifying credentials , WFM.09 Staff Performance Evaluation.

WFM.16 Legal requirements governing the professional regulation of other healthcare practitioners are followed.

Effectiveness

Keywords:

Other healthcare practitioners' job responsibilities

Intent:

A healthcare practitioner is an individual other than a physician or dentist licensed or otherwise authorized to provide healthcare services. Other qualified healthcare practitioners include physical, speech, occupational, and massage therapists, nutritionists, psychologists, etc.

The hospital is responsible for identifying the types of activities or range of services these individuals will provide in the hospital. This can be accomplished through agreements, job assignments, job descriptions, or other methods. In addition, the hospital defines the level of supervision (consistent with existing laws and regulations), if any, for these professionals.

Survey process guide:

- GAHAR surveyor may review the other healthcare practitioners' framework documents to check compliance with the laws and regulations.

Evidence of compliance:

1. Licensure, education, training, and experience of other healthcare practitioners are used to make clinical work assignments.
2. The process considers relevant laws and regulations.
3. The process supports the staffing process for other healthcare practitioners.
4. When a violation of other healthcare practitioners' laws or regulations is identified, corrective actions are taken.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.02 Staffing Plan, WFM.04 Job Description , WFM.05 Verifying credentials , WFM.09 Staff Performance Evaluation.

WFM.17 The hospital ensures safe and efficient working hours.

Safety

Keywords:

Working Hours

Intent:

Attention to the health and well-being of healthcare professionals becomes even more crucial when considering that employees represent a hospital's most significant expense.

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 professionals; many studies have demonstrated that healthcare professional burnout is detrimental to patient care. For example, the number of major medical errors a surgeon commits is correlated with the surgeon's degree of burnout and the likelihood of being involved in a malpractice suit.

Higher levels of burnout among nurses are associated with higher rates of patient mortality and the dissemination of healthcare-transmitted infections.

The hospital shall develop a policy and procedures to ensure management of staff working hours efficiently to avoid burnout that addresses at least the following:

- a) Measures to avoid staff burnout.
- b) Planned rest times.
- c) Maternity protection and arrangements for breastfeeding.

Survey process guide:

- GAHAR surveyor may review approved hospital policy.
- GAHAR surveyor may interview staff to inquire about the measures taken to ensure appropriate working hours.

Evidence of compliance:

1. The hospital has an approved policy to ensure safe and efficient working hours. The policy addresses a) to c) in the intent.
2. Staff are aware of the hospital's 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:

OGM.16 Staff rest areas, OGM.17 Staff Health program, QPI.02 Performance Measures.

Information Management and Technology

Chapter intent

Information Management and Technology (IMT) has emerged as a cornerstone of modern healthcare delivery. Its efficacy in providing timely, relevant information to decision-makers is indispensable for optimizing patient care. At the heart of IMT lies the management of clinical, administrative, and regulatory data. While IMT offers immense potential for improving healthcare outcomes, it also introduces significant challenges, primarily centered around patient confidentiality and the potential for errors due to misinterpretations. Patient confidentiality is paramount in healthcare. The disclosure of personal and medical information without explicit patient consent constitutes a severe ethical and legal breach. The integration of technology in healthcare has exacerbated this concern due to the increased vulnerability of sensitive data. Robust security measures must be in place to safeguard patient information. Another critical issue is the use of abbreviations in medical documentation. These can lead to misunderstandings and potentially catastrophic errors. To mitigate this risk, hospitals must adhere to standardized abbreviation lists, such as those provided by the Institute for Safe Medication Practices (ISMP). Importantly, these lists should be translated into local languages to ensure universal understanding. The healthcare landscape is rapidly evolving with the adoption of technologies like telehealth, artificial intelligence, and clinical decision support systems. These advancements hold the promise of enhanced patient care, improved efficiency, and better outcomes. However, their successful implementation necessitates substantial resource allocation to ensure patient safety, continuity of care, and data security.

During GAHAR Survey, surveyors shall be able to measure how hospitals implement information management systems and technologies through reviewing documents pertinent to this chapter and doing patient tracers and interviews with staff. The leadership interview session may touch on this topic, as well.

Chapter purpose:

1. To address Effective Information Management Processes
2. To Maintain Information Confidentiality and Security
3. To ensure the Availability of patients' medical records
4. To describe effective Information Technology in Healthcare.

Standards included in this chapter applies to paper and electronic data and information.

IMT chapter Summary of Changes*Summary of Changes Chapter 14*

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
IMT.01 KW: Information Management Processes	IMT.01 KW: Information Management Processes	4) No changes
IMT.02 KW: Information management plan	IMT.02 KW: Information management plan	1) Modified EOCs: (EOC.02: The hospital has an approved and effective information management plan that includes items from a) through f) in the intent). 2) Added new EOCs <ul style="list-style-type: none"> • (EOC.04: The health information system is overseen by a qualified individual). • (EOC.05: The clinical codes match those provided by health authorities and/or third-party payers.)
IMT.03 KW: Document control system.	IMT.03 KW: Quality Management System Documents	3) Rephrasing of standard statement to be: (The hospital establishes a document control system for its key functions). 4) Modified EOCs: <ul style="list-style-type: none"> • (EOC.01: The hospital has an approved document control policy that addresses at least elements from a) to f) in the intent). • (EOC.05: Policies and procedures are revised at least every three years, and each document type has defined validity). 5) Rephrasing of EOC: (EOC.03 & EOC.04).
IMT.04 KW: ٤ Abbreviations	IMT.04 KW: ٤ Abbreviations	1) Modified standard statement (The hospital defines standardized symbols and abbreviations).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<p>2) Modified EOC: (EOC.03: Symbols and abbreviations, including the approved list, are used according to the policy).</p> <p>3) Added a new EOC: (EOC.04: Violation of the list of not-to-use symbols/abbreviations is monitored, and corrective actions are taken).</p>
IMT.05 KW: Confidentiality and Security of data and information	IMT.05 KW: Confidentiality and Security of data and information	<p>9) Modified standard statement (The hospital maintains data and information confidentiality and security).</p> <p>10) Modified EOC (EOC.01: The hospital has an approved policy that includes all the points in the intent from a) through g).</p>
IMT.06 KW: Integrity of Data and Information	IMT.06 KW: Integrity of Data and Information	2) No changes
IMT.07 KW Retention of Data and Information	IMT.07 KW Retention of Data and Information	1) Modified EOC: (EOC.02: All involved staff are aware of the policy requirements).
IMT.08 KW: Patient's Medical record Management	IMT.08 KW: Patient's Medical record Management	4) Rephrasing of standard statement to be: (The Patient's medical record is managed to ensure effectiveness).
IMT.09 KW: Medical Record Review	IMT.09 KW: Medical Record Review	<p>1) Rephrasing of standard statement to be: (The hospital establishes the patient's medical record review process).</p> <p>2) Rephrasing of EOC (EOC.03: The hospital leaders are reported on the medical record review's findings).</p>
IMT.10 KW: Health information	IMT.10 KW: Health information technology evaluation	1) Modified standard statement (Health information technology

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
technology evaluation		systems are assessed and tested before implementation). 2) Added a new EOC: (EOC.04: Corrective actions are taken when defective issues are detected).
IMT.11 KW: Downtime of Data Systems	IMT.11 KW: Downtime of Data Systems	6) No changes
IMT.12 KW: Data Back-up	IMT.12 KW: Data Back-up	1) No changes

Effective information management processes

IMT.01 Information management processes are implemented according to applicable laws and regulations.

Effectiveness

Keywords:

Information Management Processes

Intent:

Management Information System is a system that provides managers with the necessary information to make decisions about an organization's operations. The system's processes mainly gather data from various sources and processes to provide information tailored to the managers and their staff's needs. Local laws and regulations address topics related to the information management process, including confidentiality and release of patient information, the retention period for documents, and reporting of specific information to inspecting and regulatory agencies.

The hospital has to make the necessary efforts and take steps to comply with relevant laws and regulations in the field of information management.

Survey process guide:

- GAHAR surveyor may perform an interactive staff interview asking to demonstrate the process of information management compliance with requirements of law and regulations followed by a review of related documents, which include response to required reports from inspecting and regulatory agencies.
- GAHAR surveyor may review the necessary reports from outside authorities or inspecting agencies, as well as the timeliness of responses and actions made in response to their inquiries.

Evidence of compliance:

1. The hospital leadership and responsible information management staff members are aware of the requirements of law and regulations.
2. The hospital stores all its records and information according to law and regulations.
3. The hospital responds timely to any required reports from inspecting and regulatory agencies.
4. When gaps are identified, steps and interventions are needed to comply with laws and regulations.

Related standards:

IMT.02 Information management plan , OGM.04 Hospital Director , IMT.07 Retention of Data and Information , IMT.05 Confidentiality and Security of data and information

IMT.02 Information management plan meets information needs.

Effectiveness

Keywords:

Information management plan

Intent:

An information plan includes the identification of the information needs of different departments, external authorities, and agencies and the implementation of a process to meet those needs. The information

plan aims to provide accurate, meaningful, comprehensive, and timely information to assist in an information-based decision-making process.

International Classification of Diseases (ICD) and International Classification of Health Interventions (ICHI) provide a common language that allows health professionals to share standardized information worldwide. The code is used to transform descriptions of medical diagnoses or procedures into standardized statistical code in a process known as clinical coding. Diagnosis classifications list diagnosis codes, which are used to track diseases and other health conditions. Procedure classifications list procedure codes, which are used to capture interventional data. These diagnosis and procedure codes are used by healthcare providers, government health programs, private health insurance companies, workers' compensation carriers, software developers, and others for various applications in medicine, public health, and medical informatics.

The hospital shall develop an information management landscape in response to identified needs, and a qualified individual should oversee the health information system. Development of an effective information management plan shall include at least the following:

- a. The identified information needs of clinical and managerial hospital leaders.
- b. The information needs and requirements of external authorities and agencies.
- c. The type and volume of services provided by the hospital.
- d. Clinical coding (diagnosis and procedure codes).
- e. The adequate timeframe required for the information dissemination process (internal or external dissemination).
- f. Education and training of staff according to their responsibilities, job descriptions, and data and information needs.

Survey process guide:

- GAHAR surveyor may review the information management plan, followed by checking the implementation of the plan through an interactive staff interview to demonstrate the process of information needs assessment and actions taken to meet identified needs.
- GAHAR surveyor may review the patient's medical record to ensure matching with the clinical code provided by health authorities and/or third party.
- GAHAR surveyor may review the staff file of the individual who oversees the health information system (HIS).

Evidence of compliance:

1. The hospital has an information needs assessment.
2. The hospital has an approved and effective information management plan that includes items from a) through f) in the intent.
3. The hospital leadership ensures that actions are taken to meet identified information needs.
4. The health information system is overseen by a qualified individual.
5. The clinical codes match those provided by health authorities and/or third-party payers.

Related standards:

IMT.01 Information Management Processes , IMT.03 Document control , IMT.10 Health information technology evaluation , OGM.08 Hospital leaders , OGM.09 Departmental management , OGM.12 Billing System , WFM.05 Verifying credentials , WFM.08 Continuous Education Program, WFM.06 Staff Files

Effective quality management system

IMT.03 The hospital establishes a document control system for its key functions.

Effectiveness

Keywords:

Document control system.

Intent:

The hospital establishes a uniform and consistent method for developing, approving, tracking, and revising its documents (such as policies, plans, programs, procedures, guidelines, and others) to prevent duplication, discrepancies, omissions, misunderstandings, and misinterpretations.

The issuing and changes tracking system allows staff to easily identify relevant policies and procedures, programs, plans, and guidelines and ensures that staff are informed about changed policies.

The hospital shall develop and implement a policy and procedures for a document control system that addresses at least the following:

- a) Standardized formatting
- b) Document control system for tracking issues and changes/modifications.
- 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 the 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.

Survey process guide:

- GAHAR surveyor may perform a document review for the policy, followed by checking the implementation of the policy by reviewing the related documents, which include the hospital 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 about the development process, 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 hospital has an approved document control policy that addresses at least elements from a) to f) in the intent.
2. The hospital 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. Only the last updated versions of documents are accessible and distributed between staff.
5. Policies and procedures are revised at least every three years, and each document type has defined validity.

Related standards:

IMT.02 Information management plan , QPI.02 Quality improvement Plan(s), IMT.07 Retention of Data and Information , IMT.10 Health information technology evaluation

IMT.04 GSR.29 The hospital 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 hospital shall develop a policy and procedures for approved and non-approved symbols and abbreviations according to the hospital scope of service and approved official language of communication inside the hospital 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 hospital about the patient's care.

Survey process guide:

- GAHAR surveyor may review hospital 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 hospital 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

Patient-centred confidentiality and security of information

IMT.05 The hospital maintains data and information confidentiality and security.

Patient-centeredness

Keywords:

Confidentiality and Security of data and information

Intent:

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.

Confidentiality means the property that health information is not made available or disclosed to unauthorized persons or processes. Integrity means the property that health information has not been altered or destroyed in an unauthorized manner. Availability means the property that health information is accessible and useable upon demand by an authorized person.

The hospital defines 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. All staff must be committed to information confidentiality and security by signing an agreement that they understand the details of the confidentiality policy and procedures and know their roles well.

The hospital shall develop and implement a policy and procedures to ensure information confidentiality and security that addresses at least the following:

- a) Determination of who can access what type of data and information.
- 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 secure the confidentiality of patient information that is communicated through e-mail or mobile devices. (e.g., implement end-to-end encryption for email and messaging services, use secure email platforms or services specifically designed for healthcare communication, use secure messaging apps that comply with healthcare privacy regulations, etc.)
- f) Staff training on the proper handling of patient information, the risks associated with insecure communication methods, and how to use secure communication tools effectively.
- g) Procedures to follow if confidentiality or security of information has been breached.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding information confidentiality and security, followed by checking the implementation through reviewing related documents such as a list of authorized individuals to have access to the patient's medical record and a signed confidentiality agreement in each staff member's personal file.
- GAHAR surveyor may observe the implementation of confidentiality measures, including storage of patient's medical records in a limited access place, each staff use of passwords, and staff having no access to information not related to their job.
- GAHAR surveyor may interview staff to assess staff awareness of confidentiality measures

Evidence of compliance:

1. The hospital has an approved policy that includes all the points in the intent from a) through g).
2. All staff are aware of the policy requirements.
3. There is a list of authorized individuals with access to the patient's medical record.
4. Only authorized individuals have access to patient's medical records.
5. There is a signed confidentiality agreement in each staff member's personal file.
6. Procedures are followed if confidentiality or security of information has been breached.

Related standards:

PCC.02 Patient and family rights , WFM.06 Staff Files, IMT.08 Patient's Medical record Management , IMT.02 Information management plan , ATH.09 Research Patient Rights , IMT.07 Retention of Data and Information , IMT.10 Health information technology evaluation , IMT.09 Medical Record Review

IMT.06 Patient's medical record and information are protected from loss, destruction, tampering, and unauthorized access or use.

Safety

Keywords:

Integrity of Data and Information

Intent:

Data integrity is a critical aspect of the design, implementation, and usage of any information system that stores, processes, or retrieves data as it reflects the maintenance, assurance, accuracy, and consistency of data over its entire life cycle.

Any unintended changes to data as the result of a storage, retrieval, or processing operation, including malicious intent, unexpected hardware failure, and human error, is the failure of data integrity.

Patient's medical records and information are protected at all times and in all places, including protecting it from water, fire, or other damage, as well as unauthorized access. Keep security policies current and decrease the likelihood and/or impact of electronic health information being accessed, used, disclosed, disrupted, modified, or destroyed in an unauthorized manner.

Ensure that the spaces where medical records and data are kept secure and only accessible to those who need them. Medical records and server storage areas must implement measures to ensure protection, e.g., controlled access and suitable types of fire extinguishers.

Survey process guide:

- GAHAR surveyor may interview staff to assess the process of information protection from loss, destruction, tampering, and unauthorized access or use.
- GAHAR surveyor may observe the patient's medical records protection measures (including the suitable type of fire extinguishers, water protection, controlled access, etc.) in archiving, storage, computer areas, or other places, including medical records.

Evidence of compliance:

1. Medical records and information are secured and protected at all times.
2. Medical records and information are secured in all places that handle medical records, including patient care areas and the medical records department.
3. The medical records department and server storage area implement measures to ensure medical information integrity.
4. When an integrity issue is identified, actions are taken to maintain integrity.

Related standards:

IMT.05 Confidentiality and Security of data and information, IMT.01 Information Management Processes , IMT.10 Health information technology evaluation , EFS.03 Fire and smoke safety

IMT.07 Retention time of records, data, and information is performed according to applicable laws and regulations.

Timeliness

Keywords:

Retention of Data and Information

Intent:

Medical records, data, and information are essential in patient care, legal documentation, continuity of care, research, and education, so the hospital must retain them for a sufficient period of time.

Different data retention policies balance legal and privacy considerations with economic factors and need-to-know requirements to determine the duration of retention, archival procedures, data formats, and acceptable methods for storage, access, and encryption. The hospital shall develop and implement a policy and procedures on data and information retention that addresses at least the following:

- a) Retention time for each type of document.
- b) Information confidentiality must be maintained during the retention time.
- c) Retention conditions, archival rules, data formats, and permissible means of storage, access, and encryption.
- d) Data destruction procedures.

Survey process guide:

- GAHAR surveyor may review the hospital policy for data and information retention time.
- GAHAR surveyor may review the list of retention time for different types of information.
- GAHAR surveyor may interview staff to check their awareness about records archival rules, retention process, and destruction and/or removal of records, data, and information.
- GAHAR surveyor may observe the record/logbook of document destruction and/or removal.
- GAHAR surveyor may observe the patient's medical records storage area, including controlled access and cameras, to ensure the confidentiality of information and may ensure following the hospital archival rules.

Evidence of compliance:

1. The hospital has an approved policy that includes all the points in the intent from a) through d).
2. All involved staff are aware of the policy requirements.
3. The information confidentiality is maintained during the retention time.
4. Data are archived as per policy.
5. Destruction and/ or removal of records, data, and information are done as per law, regulation, and hospital policy and procedures.

Related standards:

IMT.05 Confidentiality and Security of data and information , IMT.01 Information Management Processes , IMT.08 Patient's Medical record Management , IMT.03 Document control

Availability of patient-specific information

IMT.08 The Patient's medical record is managed to ensure effectiveness.

Effectiveness

Keywords:

Patient's Medical record Management

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 hospital 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 hospital 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 hospital shall develop and implement a policy and procedures for medical record management that addresses at least the following:

- a) Medical record flow management; Initiation of a patient's medical record, unique identifiers generation, tracking, storing, and availability when needed to healthcare professionals,
- b) Medical record contents and order uniformity.
- c) Medical record standardized use.
- d) Patient's medical record release.
- e) Management of voluminous patient's medical records.

Survey process guide:

- GAHAR surveyor may review the hospital 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 hospital.

Evidence of compliance:

1. The hospital has an approved policy for medical record management that includes all the items in the intent from a) through e).
2. All 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.
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.

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.09 The hospital establishes the patient's medical record review process.

Effectiveness

Keywords:

Medical Record Review

Intent:

The Hospital ensures through the medical record review that they have accurate, current, clinically pertinent, complete, and readily available medical records to ensure the continuous patient care process. Medico-legal requirements and medical research recommend action when problems arise in relation to medical records and the medical filing service.

The hospital shall develop and implement a policy and procedures that assess the content and the completeness of patient's medical record that addresses at least the following:

- a) Random sampling and selecting approximately 5% of patient's medical records.
- b) Review of a representative sample of all services.
- c) Review of a representative sample of all disciplines/staff.
- d) Involvement of representatives of all disciplines who make entries.
- e) Review of the completeness and legibility of entries.
- f) Review occurs at least quarterly.

Survey process guide:

- GAHAR surveyor may review the policy of patient's medical record review.
- GAHAR surveyor may interview staff to assess their awareness of the process of reviewing patient's medical records.
- GAHAR surveyor may review the process and check results of medical record completeness, reporting, and actions taken to improve performance.

Evidence of compliance:

1. The hospital has an approved policy that includes all the points in the intent from a) through f).
2. All staff who are using the patient's medical records are aware of the policy requirements.
3. The hospital leaders are reported on the medical record review's findings.
4. Corrective interventions are taken when needed.

Related standards:

IMT.03 Document control , IMT.04 Abbreviations , IMT.05 Confidentiality and Security of data and information , IMT.08 Patient's Medical record Management , QPI.05 Performance Measures

Effective information technology in healthcare

IMT.10 Health information technology systems are assessed and tested before implementation.

Efficiency

Keywords:

Health information technology evaluation

Intent:

Hospitals should consider investing in health information technology as a valuable resource. Implementation of health information technology systems can facilitate coordination of workflow and 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 integration with all interacting processes. Following implementation, evaluation of the usability and effectiveness of the system must be done continuously.

Survey process guide:

- GAHAR surveyor may conduct an interactive staff interview where they are asked to explain the selection, implementation, and evaluation processes for information technology.
- GAHAR surveyor may check that the evaluation processes have been followed by reviewing the relevant documents, which may include system evaluation results and hospital leader support for the identified issues related to patient safety and quality of work.

Evidence of compliance:

1. Health information technology stakeholders participate in the selection, implementation, and evaluation of information technology.
2. Health information technology systems are assessed and tested before implementation.
3. Health information technology systems are evaluated following implementation for usability, effectiveness, and patient safety.
4. Corrective actions are taken when defective issues are detected.

Related standards:

IMT.02 Information management plan , IMT.05 Confidentiality and Security of data and information , IMT.03 Document control

IMT.11 Response to planned and unplanned downtime of data systems is tested and evaluated.

Efficiency

Keywords:

Downtime of Data Systems

Intent:

A downtime event is any event where a health information technology system is unavailable or fails to perform as designed. The downtime may be scheduled (planned) for purposes of maintenance or upgrading the system or unplanned due to unexpected failure. These events may significantly threaten the safety of care delivery and the interruption of organizational operations, in addition to the risk of data loss.

The hospital shall develop and implement a program to ensure the continuity of safe patient care processes during planned and unplanned downtime, including the alternative paper forms and other

resources required. The program includes the downtime recovery process to ensure data integrity. Unplanned events are documented and investigated to determine corrective actions. All staff receive training about the transition into a downtime environment to respond to immediate patient care needs.

Survey process guide:

- GAHAR surveyor may perform a document review of the planned and unplanned downtime program, followed by checking the implementation of the process by reviewing the related documents, which include departmental workflow and work instructions for planned and unplanned downtime, stock of needed forms to be used during downtime and the result of annual program testing.
- GAHAR surveyor may review documented events for unplanned downtime events and action taken.
- GAHAR surveyor may interview staff to assess awareness about the response to planned and unplanned downtime.

Evidence of compliance:

1. There is a program for response to planned and unplanned downtime.
2. The program includes a downtime recovery process.
3. The staff is trained in response to the downtime program.
4. The hospital tests the program at least annually to ensure its effectiveness.

Related standards:

IMT.02 Information management plan , IMT.03 Document control , IMT.10 Health information technology evaluation

IMT.12 Data backup process is defined.

Safety

Keywords:

Data Back-up

Intent:

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, so having a backup is essential for data protection. Backups must occur regularly to prevent data loss, and backup data may be stored inside or outside the hospital. In both cases, the hospital ensures that backup information is secure and accessible only by those authorized to use it to restore lost data.

Survey process guide:

- GAHAR surveyor may review the process by asking stakeholders and checking the implementation of the data backup process.

Evidence of compliance:

1. There is a process for data backup, including the type of data, frequency of backup, and location.
2. Backups are performed on a scheduled basis to meet user requirements.
3. Backup schedules are developed for all new systems, and the restore is tested.
4. Backup data is secured during extraction, transfer, storage, and retrieval.

5. Backup log is reviewed frequently to identify exceptions/failures.

Related standards:

IMT.07 Retention of Data and Information , IMT.05 Confidentiality and Security of data and information ,
IMT.11 Downtime of Data Systems

Quality and Performance Improvement

Chapter intent:

Organizations must have a robust framework to support continuous improvement and risk management activities. This framework requires strong leadership support, well-established processes, and active participation from all department heads and staff. Performance improvement and risk management are integral components of both strategic and departmental operational plans.

Hospitals must cultivate a culture of continuous improvement to enhance healthcare quality and safety. Establishing a robust framework, such as a multidisciplinary performance improvement, patient safety, and risk management committee, is essential. Quality improvement plans, effective risk management, incident reporting, and sentinel events management are critical components. These elements ensure that hospitals systematically identify and address areas for improvement, fostering a proactive approach to patient care and staff safety. By integrating these practices, hospitals can continuously monitor performance, manage risks, and maintain high standards of care.

While GAHAR standards do not prescribe specific improvement tools or performance measures, they do require a minimum number of monitoring indicators. Among the various improvement opportunities, GAHAR standards emphasize enhancing the patient journey and utilization management. It is crucial for everyone in the hospital to understand their role in improving healthcare quality and safety. This involves focusing on leadership support, departmental input and participation, data collection, and sustaining improvements. The implementation of these standards must comply with applicable laws and regulations.

Chapter purpose:

The main objective is ensuring the hospital provides an effective performance improvement program.

The chapter discusses the following objectives:

- 1) Effective leadership support
- 2) Effective departmental participation
- 3) Effective performance measurement and data management
- 4) Effective improvement of sustainability

QPI chapter Summary of Changes*Summary of Changes Chapter 15*

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
QPI.01 KW: Quality Committee (s)	QPI.01 KW: Quality Committee (s)	1) Added a new EOC (EOC.04 : Committees' minutes of meetings are recorded and communicated to involved staff members.)
QPI.02 KW: Quality improvement Plan(s)	QPI.02 KW: Quality improvement Plan(s)	3) Rephrasing of Standard statement to be: (There is/are hospital-wide quality improvement and patient safety plan(s). 4) Modified EOC.01 (The hospital has an updated and approved quality improvement, and patient safety plan(s) that defines at least items from a) through j) in the intent.
QPI.03 KW: Quality management Team	QPI.03 KW: Quality management Team	1) Added a new EOC: (EOC.01: A qualified and experienced quality director supervises the quality management and improvement activities.) 2) Rephrasing:(EOC.02: Quality management functions have individual(s) with knowledge, skills, and experience in quality-related activities with clear job descriptions and appropriate numbers.) 3) Added a new EOC: (EOC.04: The top management supports the implementation of hospital-wide improvement activities with all the resources needed).
QPI.04 KW: Staff Participation in Quality Management Activities	QPI.04 KW: Staff Participation in Quality Management Activities	2) Rephrasing of all EOCs in this standard.
QPI.05 KW: Performance Measures	QPI.05 KW: Performance Measures	1) Rephrasing of Standard statement to be: (The hospital develops a process for performance measures selection and monitoring that is consistent with significant processes).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<ol style="list-style-type: none"> 1) Added a new EOC: (EOC.01: There is an identified and approved list of performance measures consistent with significant processes). 2) Rephrasing of all EOCs (EOC.02/EOC.03/EOC.04/EOC.05).
QPI.06 KW: Clinical Performance Measures	QPI.06 KW: Clinical Performance Measures	<ol style="list-style-type: none"> 1) Modified EOC: (EOC.01: The hospital selects appropriate clinical care performance measures consistent with its scope of services and relevant care areas mentioned from a) through j) in the intent. 2) Rephrasing of all EOCs: (EOC.02, EOC.03, EOC.04).
QPI.07 KW: Managerial Performance Measures	QPI.07 KW: Managerial Performance Measures	<ol style="list-style-type: none"> 1) Modified EOC: (EOC.01: The hospital selects appropriate managerial performance measures consistent with its scope of services and relevant care areas mentioned from a) through h) in the intent). 2) Rephrasing of all EOCs: (EOC.02, EOC.03, EOC.04).
QPI.08 KW: Data aggregation, analysis and validation.	QPI.08 KW: Data aggregation, analysis and validation. QPI.09 KW: Data Validation	<ol style="list-style-type: none"> 1) Updated standard (QPI.08) by merging two standards (QPI.08 & QPI.09) in Hospital edition 2021.
QPI.9 KW: Risk Management Program	QPI.10 KW: Risk Management Program	<ol style="list-style-type: none"> 1) Rephrasing of Standard statement to be: (The hospital develops a risk management program and/or plan). 2) Modified EOC: (EOC.01: The hospital has a risk management program and/or plan that includes all the elements from a) to i) in the intent). 3) Rephrasing of (EOC.02/EOC.04). 4) Added a new EOCs:

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<ul style="list-style-type: none"> • (EOC.03: Risk mitigation processes are developed based on identified risks). • (EOC.05: Results of risk management activities are communicated at least quarterly to the governing body.)
QPI.10 KW: Incident Reporting System	QPI.11 KW: Incident Reporting System	<ol style="list-style-type: none"> 1) Rephrasing of standard statement to be: (The hospital has an incident-reporting system). 2) Modified EOC: (EOC.01: The hospital has an approved incident-reporting system that includes items from a) through f) in the intent). 3) Added a new EOCs: <ul style="list-style-type: none"> • (EOC.02: All staff are aware of the incident-reporting system, including contracted and outsourced services). • (EOC.03: All reported incidents are investigated, and service gaps are identified). • (EOC.04: Corrective and/or preventive actions are taken to close gaps in services in a timely manner). • (EOC.05: The hospital communicates with patients/service users about adverse events they are affected by and provides both immediate and ongoing assistance).
QPI.11 KW: Sentinel events	QPI.13 KW: Sentinel events	<ol style="list-style-type: none"> 4) Rephrasing of standard statement to be: (The hospital defines, reports, investigates sentinel events, and takes corrective and preventive actions.) 5) Modified EOC: <ul style="list-style-type: none"> • (EOC.01: The hospital has a sentinel events management policy that includes items in the intent from a) through g), and leaders are aware of the policy requirements).

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
		<ul style="list-style-type: none"> • (EOC.03 to be: (All sentinel events from i) through xi) in the intent are communicated to GAHAR within 2 working days of the event or becoming aware of the event.) <p>6) Rephrasing of (EOC.04 : Leaders take corrective and preventive action based on identified root cause analysis.)</p> <p>7) Added a new EOC: (EOC.05: Results of root cause analysis with related actions are reported to the hospital governing body and GAHAR.)</p>
QPI.12 KW: Sustaining Improvement	QPI.14 KW: Sustaining Improvement	<p>1) Rephrasing of standard statement to be: (Sustained improvement activities are performed within the approved time frame).</p> <p>2) Rephrasing of EOCs: (EOC.01/EOC.02).</p> <p>3) Added a new EOC: (EOC.05: The hospital conducts at least one utilization improvement project annually).</p>

Effective leadership support

QPI.01 The quality improvement activities are governed by a multidisciplinary performance improvement, patient safety, and risk management committee(s).

Efficiency

Keywords:

Quality Committee (s)

Intent:

Performance improvement, patient safety, and risk management committee(s) are responsible for providing oversight and making recommendations to the governing body concerning matters pertaining to the effectiveness, efficiency, and appropriateness of quality, safety, and risk management of health services provided across the hospital. Oversight aims to improve performance, governance, and hospital effectiveness and ensure the plan will be directed and managed daily.

The hospital shall establish a multidisciplinary committee(s) for performance improvement, patient safety, and risk management, with a membership of top leaders as committee chairpersons. The committee(s) shapes the quality culture of the facility through terms of references that include at least:

- a) Ensuring that all designated care areas participate in quality improvement activities.
- b) Establishing organization-wide priorities for improvement.
- c) Ensuring that all required measurements are monitored, including the frequency of data collection.
- d) Reviewing adverse events, near-misses, and root cause analyses to prevent recurrences.
- e) Developing and implementing strategies to enhance patient safety and minimize risks.
- f) Monitoring compliance with regulatory and accreditation standards related to quality and safety.
- g) Reviewing patient satisfaction data and identifying opportunities to enhance patient experience.
- h) Reporting information about performance data and quality improvement activities to the governing body, hospital leaders, and appropriate staff members.
- i) Evaluating the performance of the committee on an annual base.

The periodic meeting provides the required information and feedback about plans and activities. It also improves collaboration, provides an opportunity to evolve as a team, and helps comply with laws and regulatory requirements.

Survey process guide:

- GAHAR surveyor may review the terms of reference of the multidisciplinary performance improvement, patient safety, and risk management committee.
- GAHAR surveyor may review the committee's meeting minutes and check that all recommendations are communicated to all involved staff members.
- GAHAR surveyor may interview the designated committee(s) chairperson and committee members to inquire about the hospital's quality and patient safety activities.

Evidence of compliance:

1. There is a multidisciplinary performance improvement, patient safety, and risk management committee(s) in compliance with relevant laws and regulations, including items from (a) to (i) in the intent.
2. There is an official assignment document for the designated committee(s) chairperson who leads and actively participates in the committee(s) meetings.
3. The committee(s) meets at predefined intervals.
4. Committees' minutes of meetings are recorded and communicated to involved staff members.
5. The committee(s) evaluates its performance on an annual basis.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital director, OGM.08 Hospital leaders, OGM.05 Committee structure, QPI.02 Quality improvement Plan(s), QPI.09 Risk Management Program, QPI.05 Performance Measures, QPI.10 Incident Reporting System, APC.03 Sustaining compliance with accreditation standards

QPI.02 There is/are hospital-wide quality improvement and patient safety plan(s).

Effectiveness

Keywords:

Quality improvement Plan(s)

Intent:

Performance improvement is an ongoing process that helps the hospital continually find new and better ways to improve patient care, increase satisfaction, and achieve even better clinical outcomes.

Leadership, starting with the governing body and hospital leaders, is essential for developing and implementing the quality improvement plan(s). The hospital leaders are responsible for establishing and providing ongoing support for a hospital's commitment to measure, assess, and improve quality, patient safety, and risk management. Leaders also determine how the plan(s) will be directed and managed daily, how the committee will achieve collaboration, and how the plan will have adequate resources. The plan(s) is/are updated annually and approved by the governing body. Leaders developed quality improvement, patient safety, and risk management plan(s) that address at least the following:

- a) Quality policy and mission statement: The hospital's mission statement clearly defines its commitment to providing high-quality care and patient safety.
- b) The goal(s) and objectives (clinical and managerial) that fulfill the hospital mission.
- c) The role of leaders and defined responsibilities of improvement activities.
- d) Performance measures road map selection.
- e) Data collection, data analysis tools, and validation process.
- f) Information flow and reporting frequency.
- g) Defined criteria for prioritization and selection of performance improvement projects.
- h) Quality improvement model(s) used.
- i) Training on quality improvement and patient safety approaches.
- j) The plan(s) is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the hospital quality and patient safety improvement plan.
- GAHAR surveyor may interview hospital leaders about the plan contents, staff training related to quality concepts, data management, and plan(s) implementation in different leadership clinical and non-clinical areas.

Evidence of compliance:

1. The hospital has an updated and approved quality improvement and patient safety plan(s) that defines at least items from a) through j) in the intent.
2. Staff is aware of performance improvement and patient safety plan(s).
3. Hospital directors and leaders actively participate in planning, supporting, and monitoring performance improvement and patient safety.

4. The plan is communicated to the relevant stakeholders.
- 5) The plan(s) is/are implemented hospital-wide, according to the timetable.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital Director , OGM.08 Hospital leaders, OGM.02 Mission Statement, QPI.05 Performance Measures

QPI.03 A qualified quality team is assigned and supported by resources.

Effectiveness

Keywords:

Quality management team

Intent:

Leadership support is an essential factor in the implementation of quality functions and activities. The main support of the leadership is logistic support in terms of providing all the needed resources to facilitate the work of the quality team, which include:

- a) A qualified quality director or a leader with proper qualifications and experience in healthcare quality. The quality director must be part of the hospital's management team to supervise the quality activities, provide the other members of management with all needed information, and receive proper support from them.
- b) Fully dedicated full-time staff facilitating and coordinating quality activities with a clear job description. The qualified team must be certified in healthcare quality and risk management and have the experience to support the training and facilitate the program organization-wide.
- c) Supporting the team with enough space to carry out their activities as well as the needed equipment, including computers, printers, phones, and photocopiers, is mandatory for doing their jobs.

Survey process guide:

- GAHAR surveyor may review staff files to check for the qualifications of the quality director and quality team members.
- GAHAR surveyor may assess the provided support for the quality team.

Evidence of compliance:

1. A qualified and experienced quality director supervises the quality management and improvement activities.
2. Quality management functions have individual(s) with knowledge, skills, and experience in quality-related activities with clear job descriptions and appropriate numbers.
3. The quality management team receives the required support in terms of space, equipment, and staffing.
4. The top management supports the implementation of hospital-wide improvement activities with all the resources needed.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital Director, OGM.14 Safety Culture, QPI.02 Quality improvement Plan(s), WFM.04 Job Description

Efficient department-level input and participation

QPI.04 Hospital staff, including healthcare professionals and administrative staff, participate in quality management activities.

Efficiency

Keywords:

Staff Participation in Quality Management Activities

Intent:

Engaging healthcare professionals, including physicians, dentists, pharmacists, physiotherapists, nurses, technicians, and other staff in the work of performance improvement, patient safety, and risk management, is essential in achieving excellence in clinical care and bringing it to the bedside. The implementation of quality management functions and activities requires the involvement of all hospital staff. Thus, the hospital promotes active staff involvement and prepares them to be competent and confident, and they will be stakeholders in performance improvement initiatives and build a teamwork environment.

Hospital staff members have proper knowledge about quality management activities related to their scope of practice, which enables them to participate in those activities.

Survey process guide:

- GAHAR surveyor may review staff files to check for evidence of training on quality management concepts and to check that individual performance evaluation includes quality management activities.
- GAHAR surveyors may interview staff to assess their awareness of quality management activities in the hospital and their roles in these activities.

Evidence of compliance:

1. The hospital provides training to all staff on quality management concepts.
2. Hospital staff members are aware of quality management activities running in the hospital related to their scope of practice.
3. Participation of hospital staff from different categories in quality management activities is evident through sharing in improvement projects, risk assessments, safety rounds... etc.
4. The hospital includes quality management activities in individual performance evaluation.

Related standards:

QPI.02 Quality improvement Plan(s), QPI.09 Risk Management Program, WFM.09 Staff Performance Evaluation

Efficient data management

QPI.05 The hospital develops a process for performance measures selection and monitoring that is consistent with significant processes.

Effectiveness

Keywords:

Performance Measures

Intent:

Performance measurement seeks to monitor, evaluate, and communicate the extent to which various aspects of the health system meet their key objectives. A performance measure is a quantitative variable that either directly measures or may indirectly reflect the quality of care provided. It should be aligned with accountability by enabling stakeholders to make informed decisions by collecting the data and being able to interpret it.

To define a measure properly, a description of at least the following is needed:

- a) Definition.
- b) Defined data source.
- c) Specified frequency.
- d) Sampling techniques.
- e) Formula.
- f) Methodology of data collection and analysis.
- g) Target or benchmark the results.

Data collection will create a database that is aggregated and trended over time and used for comparison over time within the hospital and for comparisons with other organizations. The performance results/data shall be made publicly available at least annually.

Survey process guide:

- GAHAR surveyor may review the approved list and the identity sheet of the performance measures of the hospital.
- GAHAR surveyors may interview the staff responsible for collecting, interpreting, and/or using performance measurements to check their awareness.
- GAHAR surveyor may review the reported results of the performance measures.

Evidence of compliance:

1. There is an identified and approved list of performance measures consistent with significant processes.
2. There is an approved documented identity sheet for each selected performance measure. A standardized template is preferred that includes all elements mentioned in the intent from a) through g).
3. Those responsible for collecting, interpreting, and/or using performance measurement are aware of its definition and specified frequency, sampling technique, used formulae, and data collection and analysis methodology.
4. The results are used in benchmarking internally and/or externally.
5. The results are reported to the governing body and those accountable for improvement and action taking.

Related standards:

QPI.02 Quality improvement Plan(s), PI.06 Clinical Performance Measures , QPI.07 Managerial Performance Measures, QPI.12 Sustaining Improvement, OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital director, APC.03 Sustaining compliance with accreditation standard

QPI.06 Clinical Care Performance Measures are used to identify opportunities for improvement and track progress toward the hospital's objectives.

Effectiveness

Keywords:

Clinical Performance Measures

Intent:

Performance measures are values that demonstrate a hospital's performance, strengths, and opportunities for improvement. Effective design and clarity of scope are crucial fundamentals in establishing and maintaining value-added business indicators.

The hospital shall select a mixture of measures that focus on activities that might be risky in nature to patients or staff, occurring in high volume, associated with problems, or high cost, and include appropriate and relevant indicators in the following areas:

- a) Waiting times in the relevant service areas.
- b) Patient assessment is complete, accurate, and within approved time frames.
- c) Invasive procedures and use of sedation.
- d) Use of medications.
- e) Patient's medical record, including availability and content.
- f) Infection prevention, control, and surveillance.
- g) Medication errors, near-miss, and adverse outcomes.
- h) Diagnostic errors.
- i) Patient safety requirements.
- j) Clinical effectiveness, e.g., clinical practice guidelines effectiveness.

The amount of data that needs to 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.

Once data has been collected for a meaningful amount of time, process improvements can begin to be evaluated. The hospital uses different charts to track the improvement progress and decides the next step in the improvement plan.

Survey process guide:

- GAHAR surveyor may review the hospital clinical care performance measures and assess the criteria for selection.
- GAHAR surveyor may interview different staff to assess their awareness of the clinical care measures used in their departments and assess data collection and results display methods.
- GAHAR surveyor may interview hospital leaders to assess how they use performance measures in their decisions.

Evidence of compliance:

1. The hospital selects appropriate clinical care performance measures consistent with its scope of services and relevant care areas mentioned from a) through j) in the intent.
2. The relevant clinical performance measure is monitored frequently.

3. Performance measures are processed and displayed in a table, curve, or graph.
4. Hospital leaders use performance measures to make decisions.

Related standards:

OGM.04 Hospital director, OGM.08 Hospital leaders, QPI.05 Performance Measures, QPI.02 Quality improvement Plan(s), QPI.12 Sustaining Improvement

QPI.07 Managerial Performance Measures are used to identify opportunities for improvement and track progress toward the hospital's objectives.

Effectiveness

Keywords:

Managerial Performance Measures

Intent:

Hospital administrators, executives, and stakeholders require robust tools to assess and enhance healthcare facilities' performance continually. This necessitates implementing Managerial Performance Measures (MPMs), a set of metrics and indicators designed to evaluate hospital management's efficiency, effectiveness, and overall performance.

MPMs supply hospital leaders with data and insights to make informed decisions. They ensure that decisions are based on evidence and align with the hospital's goals. Hospitals can also compare their performance against benchmarks and best practices, enabling them to identify areas for improvement. The hospital shall select a mixture of measures that focus on activities that might be risky in nature to patients or staff, occurring in high volume, associated with problems, or high cost, and include appropriate and relevant managerial indicators as following:

- a) Compliance with law and regulations
- b) Patient and family expectations and satisfaction
- c) Patient complaints and suggestions
- d) Staff expectations and satisfaction
- e) Staff complaints and suggestions
- f) Patient demographics, diagnoses, and procedures
- g) Procurement of routinely required supplies and medications
- h) Financial management

The amount of data that needs to 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.

Once data has been collected for a meaningful amount of time, process improvements can begin to be evaluated. The hospital uses different charts to track the improvement progress and decides the next step in the improvement plan.

Survey process guide:

- GAHAR surveyor may review the hospital managerial performance measures and assess the criteria for selection.
- GAHAR surveyor may interview different staff to assess their awareness of the managerial measures used in their departments and assess data collection and results display methods.

- GAHAR surveyor may interview hospital leaders to assess how they use performance measures in their decisions.

Evidence of compliance:

1. The hospital selects appropriate managerial performance measures consistent with its scope of services and relevant care areas mentioned from a) through h) in the intent.
2. The relevant managerial performance measures are monitored frequently.
3. Performance measures are processed and displayed in a table, curve, or graph.
4. Hospital leaders use performance measures to make decisions.

Related standards:

OGM.04 Hospital director, OGM.08 Hospital leaders, QPI.05 Performance Measures, QPI.02 Quality improvement Plan(s), QPI.12 Sustaining Improvement

QPI.08 The hospital has a process in place for data aggregation, analysis, and validation through qualified staff.

Effectiveness

Keywords:

Data aggregation, analysis, and validation.

Intent:

For the data to be useful for the decision-makers, it must be processed and aggregated to be transformed into useful information and utilized by decision-makers to make the proper decision based on data. Data analysis is the process of cleaning, changing, and processing raw data and extracting relevant information that helps businesses make informed decisions.

A qualified staff member with the appropriate knowledge, skills, and experience must be assigned to manage data related to performance improvement and improvement projects.

Data validation means checking the accuracy and quality of the data source before using it. Ensuring that data is clean, correct, and valuable is vital.

Data validation is required in the following situations:

- a) Starting a new measure in general and a clinical measure in specific
- b) Publishing the data to the community
- c) Any change in the data collection methodology
- d) Unexplained results without justification
- e) Change in the source of data
- f) Change in the scope of data collected

The hospital uses these elements of data quality for data review and validation:

- g) Validity: data measures what it is supposed to measure.
- h) Reliability: everyone defines, measures, and collects data uniformly.
- i) Completeness: data include all the values needed to calculate performance measures.
- j) Precision: data have sufficient detail.
- k) Timeliness: data are up to date. Information is available on time.
- l) Integrity: data are true.

The methods of data validation depend on the type of data. If the hospital uses manual data, the data validation method will depend on the recollecting of data through 2nd person by using a sample (most probably 5% of the previous data collected). If the hospital uses data directly from the system, data validation could be done through the system itself through applications and programs used for data validation or through the data analyst by cleansing data before analysis. The hospital shall use an evidence-based data validation method consistent with its data collection type.

Survey process guide:

- GAHAR surveyor may review the hospital 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. Staff member(s) with appropriate knowledge, skills, and experience is/are assigned for data review, aggregation, analysis, and validation.
2. Data is aggregated and analyzed to identify trends and patterns over time.
3. There is a written process for data review and validation that covers items from a) through f) in the intent.
4. Data review techniques are implemented to ensure that all the elements from g) to l) in the intent are considered.

Related standards:

QPI.02 Quality improvement Plan(s), QPI.03 Quality management Team, QPI.05 Performance Measures, QPI.12 Sustaining Improvement

Efficient risk management program

QPI.09 The hospital develops a risk management program and/or plan.

Safety

Keywords:

Risk Management Program

Intent:

Risk management is designed to identify potential events that may affect the hospital and to protect and minimize risks to the hospital property, services, and employees.

The organization needs to adopt a proactive approach to risk management, such as risk analysis, where the hospital assesses high-risk processes and develops risk mitigation strategies.

The hospital is to take reactive and proactive measures to address identified risks.

The hospital shall develop a risk management program and/or plan containing 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 hospital risk management framework
- d) Staff training on risk management concepts and tools
- e) Risk identification, including updated risk register
- f) Risk prioritization and categorization (i.e., strategic, operational, reputational, financial, others)
- g) Risk reporting and communication with stakeholders and the governing body

- h) Risk Reduction plans and tools with priority given to high risks
- i) The risk management program/plan is updated annually

Failure Mode and Effects Analysis (FMEA) is one of the analysis tools that can be used in the hospital as a proactive approach.

Survey process guide:

- GAHAR surveyor may review the hospital 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 hospital has a risk management program and/or plan that includes all the elements from a) to i) in the intent.
2. There is a risk assessment process in place with an updated risk register for all identified risks.
3. Risk mitigation processes are developed based on identified risks.
4. The hospital has an approved proactive risk reduction tool annually for at least one high-risk process.
5. Results of risk management activities are communicated at least quarterly to the governing body.

Related standards:

EFS.03 Fire and smoke safety, EFS.07 Safety Management Plan, EFS.08 Pre-Construction risk assessment, EFS.09 Security plan, EFS.13 Disaster Plan, IPC.02 IPC program, risk assessment, guideline, ACT.06 Patient's flow risks, QPI.04 Incident Reporting System, QPI.05 Sentinel events, OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital Director

QPI.10 The hospital has an incident-reporting system.

Safety

Keywords:

Incident Reporting System

Intent:

Robust risk management is supported by effective incident reporting systems. An incident is defined as any event that affects the safety of a patient, staff member, or visitor. In most hospital injuries, patient complaints, medication errors, equipment failure, adverse reactions to drugs or treatments, or errors in patient care are to be included and reported.

Incident reporting has a significant influence on improving patient safety and can provide valuable insights into how and why patients can be harmed at the hospital level. Incident reporting helps detect, monitor, assess, mitigate, and prevent patient, staff, and visitor risks. The incident-reporting system 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) Staff training on incident management process
- d) Incidents that require immediate notification to management
- e) Incident classification, analysis, and results reporting

f) Indication for performing intensive analysis and its process

Adverse events can have significant negative consequences for both patients and staff. The hospital should understand the emotional and psychological impact of such incidents and should be dedicated to offering comprehensive support to those affected, 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 list, review 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.

Evidence of compliance:

1. The hospital has an approved incident-reporting system that includes items from a) through f) in the intent.
2. All staff are aware of the incident-reporting system, including contracted and outsourced services.
3. All reported incidents are investigated, and service gaps are identified.
4. Corrective and/or preventive actions are taken to close gaps in services in a timely manner.
5. The hospital communicates with patients/service users about adverse events they are affected by and provides both immediate and ongoing assistance.

Related standards:

QPI.09 Risk Management Program, OGM.14 Safety Culture, QPI.11 Sentinel events, QPI.12 Sustaining Improvement, MMS.17 Medication errors, near miss, medication therapy problems

QPI.11 The hospital defines, reports, investigates sentinel events, and takes corrective and preventive actions.

Safety

Keywords:

Sentinel events

Intent:

According to the World Health Organization, an adverse event is an injury related to medical management, in contrast to disease complications. Adverse events may be preventable or non-preventable. A preventable adverse event is an adverse event caused by an error relevant to medical management. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care.

“Near-miss” or “close call” is a serious error or mishap that can potentially cause an adverse event but fails to do so because of chance or because it is intercepted. Also called a potential adverse event.

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury. While both adverse events and sentinel events involve harm to patients, sentinel events are a subset of adverse events that are particularly severe and demand immediate attention and investigation to prevent recurrence and improve patient safety. Thus, a sentinel event signals an immediate investigation and response. Root cause analysis is also indicated in potential sentinel events (near-miss).

The hospital shall develop a policy for sentinel event management that includes at least the following:

- a) Definitions of adverse event, near miss and sentinel event. Sentinel events include, but not limited to:
 - i. Unexpected mortality or major permanent loss of function not related to the natural course of the patient's illness or underlying condition.
 - ii. Wrong patient, wrong site, or 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. Wrong delivery of radiotherapy.
 - vi. Any peripartum maternal death.
 - vii. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.
 - viii. Major haemolytic transfusion reaction.
 - ix. Rape.
 - x. Fire.
 - xi. Infant abduction.
- b) Internal reporting of sentinel events.
- c) External reporting of sentinel events.
- d) Team member's involvement.
- e) Root cause analysis.
- f) The taken corrective and preventive action plans.
- g) Procedures for managing adverse events consequences, including the first and second victims affected.

All sentinel events are communicated to GAHAR within two working days of the event or of becoming aware of it. All events that meet the definition must have a root cause analysis to clearly understand the contributing factors behind the system gaps. The analysis and action must be completed within 45 days of the event or becoming aware of it.

Survey process guide:

- GAHAR surveyor may review the hospital policy for management of sentinel events and may interview hospital leaders to check their awareness.
- GAHAR surveyor may review a sample of reported sentinel events and assess the investigation, root cause analysis, and the corrective actions that were taken.

Evidence of compliance:

1. The hospital has a sentinel events management policy that includes items in the intent from a) through g), and leaders are aware of the policy requirements.
2. All sentinel events are investigated thoroughly and communicated by root cause analysis in a 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 from i) through xi) in the intent are communicated to GAHAR within two working days of the event or becoming aware of the event.
4. Leaders take corrective and preventive action based on identified root cause analysis.
5. Results of root cause analysis with related actions are reported to the hospital governing body and GAHAR.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.04 Hospital Director, OGM.08 Hospital leaders, QPI.09 Risk Management Program, QPI.04 Incident Reporting System, APC.01 Accurate and complete information.

Sustaining improvement

QPI.12 Sustained improvement activities are performed within the approved time frame.

Efficiency

Keywords:

Sustaining Improvement

Intent:

Although staff plays a vital part in the continuous improvement process, it is the management's role to train, empower, and encourage the staff to participate with ideas. An effective continuous improvement program needs continuous measurement and feedback. Before starting, hospital baseline performance needs to be measured, then new ideas for improving performance can follow.

The hospital shall identify the hospital-wide initiatives for improvement and use prioritization tools (e.g., prioritization matrix) to select the most important improvement opportunities on an annual basis. One of the important initiatives that need to be considered in this respect is utilization management. The hospital can ensure efficient utilization of its resources through the identification of high-frequency and high-cost processes, either clinical or non-clinical, and perform improvement projects to eliminate wastes and redundancies in these processes. Diagnostic errors are another suggestion for quality improvement initiatives. Diagnostic errors encompass failures in the diagnostic process, leading to delayed diagnosis, wrong diagnosis, or misdiagnosis. Critical diagnostic areas, including emergency departments, radiology, pathology, and laboratory services, highlight units where precise and timely diagnoses are paramount for effective healthcare delivery and patient outcomes.

Plan-Do-Check-Act (PDCA) cycle, Focus PDCA, or other improvement tools allow scientific testing of 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 measure the impacts of a continuous improvement program, which is the most effective way of sustaining it.

Survey process guide:

- GAHAR surveyor may review the hospital opportunities for improvements and assess data utilization to determine these opportunities.
- GAHAR surveyor may review hospital improvement projects and assess the tools and methodologies used for quality improvement and the improved processes.

Evidence of compliance:

1. The hospital identifies opportunities for improvement on an annual basis.
2. The hospital uses suitable quality improvement methodology/tool for improvement.
3. Improvement activities were tested, and the results were recorded and implemented.
4. There is evidence that processes were improved.
5. The hospital conducts at least one utilization improvement project annually.

Related standards:

QPI.01 Quality management program/plan, QPI.04 Performance Measures, OGM.04 Hospital director, OGM.08 Hospital leaders, OGM.11 Safety Culture, APC.03 Sustaining compliance with accreditation standard.

SECTION 4

Academic and Teaching Hospitals

Section 4: Academic and Teaching Hospitals

(ATH)

Chapter Intent:

Academic and teaching hospitals play a vital role in society by delivering high-quality patient care, promoting educational excellence for medical students and trainees, and advancing medical knowledge through research. Integrating medical education into hospital operations must align with the hospital's mission, strategic plans, resource allocation, and quality and patient safety programs. Effective governance of educational programs within teaching hospitals involves maintaining a structured curriculum, overseeing faculty qualifications, employing appropriate teaching methods, providing adequate supervision, and ensuring trainees achieve specific competencies. The standards highlighted in this chapter emphasize the importance of safety and quality of care provided to patients under the care of trainees and students as part of the hospital's services.

Clinical research, a crucial aspect of academic and teaching hospitals, is the key to fostering innovations in medical science and improving patient care. Hospitals must have a strong governance structure to oversee research activities, including a research ethics committee (REC) that reviews and monitors research protocols to protect the rights and welfare of research participants. The standards in this chapter require hospitals to implement policies for obtaining informed consent, ensuring participant confidentiality, and managing conflicts of interest. These standards also provide a framework for integrating medical education and human research into the quality and patient safety activities of academic hospitals.

Chapter purpose:

1. To Integrate Education and Research into Hospital Operations.
2. To Promote Educational Excellence.
3. To Create a Positive Learning Environment for medical students and trainees.
4. To Ensure Patient Rights and Safety.

These standards are applied in both academic and teaching hospitals.

ATH Chapter Summary of Changes

Summary of Changes Chapter 16

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
ATH.01 KW: Mission of Academic hospital.		8) New standard
ATH.02 KW: Educational Governance	ADD.01 KW: Educational Governance	4) Added new EOCs: <ul style="list-style-type: none"> • (EOC.02: The hospital establishes minimum qualifications and credentials for faculty members involved in teaching and research activities). • (EOC.03 The hospital establishes mentorship programs to support the professional development and career progression of students, residents, and early-career faculty members, with clearly defined goals and measurable outcomes). • (EOC.04 The hospital provide access to educational resources, including libraries, journals, and online databases, to support teaching activities for faculty and students.
ATH.03 KW: Curriculum development		New standard
ATH.04 KW: Patient rights during bedside teaching		New standard
ATH.05 KW: Patient safety and clinical teaching	ADD.02 KW: Safe Clinical Education Culture	3) Modified standard statement: (Patient safety is ensured and upheld during clinical teaching activities). 4) Added new EOC: (EOC.01 The hospital integrates structured patient safety education into their programs) . 5) Modified EOC: (EOC.02, EOC.04, EOC.5).
ATH.06 KW: Activities of house officers and residents	ADD.04 KW: Activities of house officers and residents	1) Modified standard statement: (house officers, residences and other trainees are oriented, working within their scope of work and involved in an educational program). 2) Modified EOC: 1. (EOC.01. The hospital has an approved orientation program to prepare trainees for their roles that includes all the points in the intent from a) through g)).
ATH.07 KW: Training of Medical Students	ADD.05 KW: Training of Speciality Medical Trainees	1. Rephrasing EOC: (EOC.04: Educators are trained to use objective assessment tools for evaluating the trainees.)

GAHAR hospital standards 2025	GAHAR hospital standards 2021	Details of changes
ATH.08 KW: Research Ethical Framework	ADD.06 KW: Research Ethical Framework	1) No changes
ATH.09 KW: Research Patient Rights	ADD.07 KW: Research Patient Rights	1) No changes

Hospital strategic management supports clinical education.

ATH.01 The mission of the hospital supports medical education.

Effectiveness

Keywords:

The mission of Academic Hospital.

Intent:

The academic/teaching hospital serves as a training ground for medical students, residents, and fellows enrolled in the affiliated school of medicine. It provides a diverse range of clinical experiences and exposure to various medical specialties, allowing students to apply their knowledge in a practical setting and develop essential clinical skills.

The mission of a teaching hospital extends far beyond healthcare delivery. It encompasses a commitment to education, research, and the cultivation of the next generation of healthcare professionals. Aligning the hospital's mission with medical education is pivotal in ensuring that its educational activities are not merely an adjunct but a fundamental component of its identity. The hospital staff should understand the critical role that medical education plays in achieving the hospital's broader goals of providing high-quality care, advancing knowledge, and improving healthcare outcomes.

Survey process guide:

- GAHAR surveyor may review the hospital's mission statement and strategic plan to ensure that the mission explicitly includes a commitment to medical education and that the strategic plan outlines objectives related to supporting and enhancing medical education within the hospital.
- GAHAR surveyor may interview staff to ensure they understand the hospital's mission and role in the educational growth of future healthcare professionals.

Evidence of compliance:

1. The hospital has a mission statement that incorporates medical education.
2. The hospital's strategic plan outlines objectives related to supporting and enhancing medical education within the hospital.
3. The hospital staff understands the hospital's role in medical education and clinical research.

Related standards:

OGM.02 Mission statement

ATH.02 An educational governance structure is established to improve the quality and outcome of clinical education.

Effectiveness

Keywords:

Educational Governance

Intent:

An educational governance structure is crucial for improving the quality and outcome of education in academic and teaching hospitals. It provides a framework for effective management, oversight, and continuous improvement of educational programs.

A well-defined governance structure ensures clear lines of leadership and accountability in educational matters. It identifies individuals or committees responsible for setting educational goals, monitoring progress, and making informed decisions to enhance the quality of education.

The hospital shall assign the responsibility of overseeing medical education activities to a committee, a task force, or a staff member to build effective systems of educational governance and leadership to manage and control the quality of medical education and training. These responsibilities shall include continuous improvement of the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

Survey process guide:

- GAHAR surveyor may review the educational governing structure and the hospital's documented assigning decision for the body responsible for overseeing medical education.
- GAHAR surveyor may interview the assigned medical education supervisor to ensure his awareness of his responsibilities and the minimum qualifications and credentials needed for faculty members.
- GAHAR surveyor may review the medical education program to check the identified minimum qualifications and credentials needed for faculty members.
- GAHAR surveyor may review the mentorship program with clearly defined goals and measurable outcomes.

Evidence of compliance:

1. The hospital clearly assigns the responsibility of medical education supervision.
2. The hospital establishes minimum qualifications and credentials for faculty members involved in teaching activities.
3. The hospital establishes mentorship programs to support the professional development and career progression of students, residents, and early-career faculty members, with clearly defined goals and measurable outcomes.
4. The hospital provides access to educational resources, including libraries, journals, and online databases, to support teaching activities for faculty and students.
5. At all times, the hospital has an appropriate level of clinical supervision by an experienced and competent supervisor who can advise or attend as needed.

Related standards:

WFM.08 Continuous education program, WFM.10 Medical Staff Structure

ATH.03 The hospital has a structured process for curriculum development, including regular review and updates, to align with best practices in clinical education.

Effectiveness

Keywords:

Curriculum development

Intent:

In the realm of clinical education, the structured development of curriculum stands as a cornerstone for the adequate preparation of future healthcare professionals. The hospital should have a process for

curriculum development that clearly outlines the steps involved, from needs assessment to curriculum design, implementation, and evaluation.

The process for curriculum development needs to be structured as well as adaptive, allowing for regular review and updates to align with the latest best practices and emerging research in clinical education. In doing so, the hospital ensures that its learners receive an education that remains not only current but at the forefront of advancements in clinical practice and teaching.

Survey process guide:

- GAHAR surveyor may review the hospital's documented curriculum development process to ensure that the process is well-documented and clearly outlines the steps.
- GAHAR surveyor may review the medical education program to check the frequency and comprehensiveness of curriculum reviews and updates and how the hospital ensures alignment with best practices in clinical education.
- GAHAR surveyor may interview the assigned medical education supervisor to inquire about the frequency of curriculum reviews and updates and how the hospital ensures alignment with best practices in clinical education.

Evidence of compliance:

1. The hospital has a well-documented curriculum development process.
2. The hospital demonstrates a precise alignment of its curriculum with recognized best practices in clinical education.
3. The hospital conducts regular, systematic reviews of its curriculum content and makes timely updates to reflect the latest research and best practices.
4. The hospital seeks stakeholder feedback and has mechanisms for incorporating feedback into curriculum improvements.

Related standards:

ATH.05 Patient safety and clinical teaching

Clinical education in support of patient's rights and safety

ATH.04 Patient rights and autonomy are respected and upheld during bedside clinical teaching activities.

Patient centeredness

Keywords:

Patient rights during bedside teaching

Intent:

Academic/teaching hospital that provides bedside teaching shall develop a policy and procedures to ensure patient rights during bedside teaching that address at least the following:

- a) Obtain verbal or written consent and ensure that patients fully understand the purpose, nature, and potential impact of their participation in teaching sessions. They also have the right to refuse or withdraw consent at any time without any negative consequences to their care.
- b) Safeguard privacy and confidentiality and take necessary measures, such as using private areas, obtaining verbal consent for learners' involvement, and refraining from discussing sensitive or identifiable patient information in public or non-confidential settings.

- c) Promote a culture of professionalism and respect among healthcare providers, learners, and patients. Educate learners about appropriate behavior, respect for patient boundaries, and the importance of maintaining a professional and ethical approach during all interactions.
- d) Prioritize patients' physical and emotional comfort and safety during bedside teaching. Take appropriate measures to minimize potential discomfort or harm to the patient, including avoiding unnecessary procedures or examinations solely for teaching purposes.
- e) Encourage feedback from patients regarding their experiences with bedside teaching. Provide a mechanism for patients to express any concerns, complaints, or suggestions related to their participation in teaching activities and ensure that these are addressed promptly and appropriately.

Survey process guide:

- GAHAR surveyor may review the hospital policy and procedures guiding patient rights during bedside teaching.
- GAHAR surveyor may interview the staff involved in bedside teaching to ensure their awareness of the hospital policy.
- GAHAR surveyor may interview patients subjected to bedside teaching to ensure that patient rights are respected.

Evidence of compliance:

1. The hospital has a policy that addresses all the items from a) to e) in the Intent.
2. The staff involved in bedside teaching are aware of the contents of the policy.
3. Verbal or written consent is obtained from patients before involvement in bedside teaching.
4. Privacy and confidentiality are safeguarded during bedside teaching.

Related standards:

PCC.02 Patient and family rights, PCC.08 Informed consent, PCC.13 Patient's dignity, privacy, and confidentiality

ATH.05 Patient safety is ensured and upheld during clinical teaching activities.

Safety

Keywords

Patient safety and clinical teaching

Intent:

Patient safety is a fundamental cornerstone of healthcare delivery and education. Within the context of clinical teaching activities, ensuring and upholding patient safety is of paramount importance. This standard highlights the critical need for a healthcare environment where patient safety is never compromised, even as learners gain valuable experience. The principles of ethics, professionalism, and quality care must remain unwavering in clinical education. This could be achieved through the following:

- Integrate patient safety principles and practices into formal medical and clinical teaching.
- Create a learning environment where learners not only acquire clinical skills but also develop a solid commitment to ethical practice, professionalism, and patient safety.
- Ensure that learners are trained to follow evidence-based practices and safety protocols during patient care.

- Develop a mechanism for reporting and learning from adverse events or near misses that may occur during clinical teaching activities.

Survey process guide:

- GAHAR surveyor may review the medical/clinical training curricula to ensure that patient safety education is integrated.
- GAHAR surveyor may interview the learners to ensure their awareness of the patient safety requirements and practices.
- GAHAR surveyor may evaluate the level of supervision and oversight provided to learners during clinical teaching activities, ensure appropriate learners' supervision, and if senior clinicians are readily available for guidance and support.

Evidence of compliance

1. The hospital integrates structured patient safety education into their programs.
2. Students and other learners are allowed to address concerns about patient safety and standard of care.
3. The hospital investigates and/or takes action to address concerns and correct them.
4. The trainees' participation in patient communication, diagnosis, and treatment is under supervision.
5. The hospital has a mechanism for reporting and learning from adverse events or near misses that may occur during clinical teaching activities.

Related standards:

ATH.03 Curriculum development, QPI.10 Incident Reporting System

Equitable and efficient clinical education

ATH.06 House officers, residents, and other trainees are oriented, work within their scope of work, and are involved in an educational program.

Effectiveness

Keywords:

Activities of house officers and residents

Intent:

The orientation and adherence to the defined scope of work for house officers, residents, and other trainees in a healthcare setting are pivotal components of a well-structured and safe educational environment. Ensuring that these learners are effectively oriented and work within their scope of responsibilities is not only crucial for their own development but also for patient safety and the overall quality of healthcare delivery.

The hospital shall develop and implement an orientation program for house officers and residents that creates a comprehensive educational experience preparing house officers and residents for successful careers in medicine. This program shall include at least the following:

- a) Clinical rotations, including regular feedback and evaluation of each clinical rotation.
- b) Didactic education.
- c) Supervision and mentorship.
- d) Patient care responsibilities.
- e) Simulation training, if applicable.

f) Assessment and evaluation.

g) Providing education on hospital policies, procedures, plans, and other quality systems.

The hospital should consider that trainees gradually assume increasing patient care responsibilities as they progress through their training. Their participation in patient communication, diagnosis, and treatment should be under supervision.

Survey process guide:

- GAHAR surveyor may review the hospital's orientation program for house officers, residents, and trainees to ensure the program's comprehensiveness and coverage of essential topics, including hospital policies, procedures, patient safety, ethics, and professional conduct.
- GAHAR surveyor may review the logbook of the house officer.
- GAHAR surveyor may interview house officers, residents, and their supervisors to check their awareness.

Evidence of compliance

1. The hospital has an approved orientation program to prepare trainees for their roles that includes all the points in the intent from a) through g).
2. House officers and residents are aware about their scope of practice.
3. House officers and residents are oriented to and comply with hospital policies and procedures.
4. House officers and residents are given protected time for learning.

Related standards:

WFM.04 Job Description, ATH.07 Training of Medical Students

ATH.07 The hospital participates in professional graduate education programs.

Effectiveness

Keywords:

Training of Medical Students

Intent:

A professional graduate education program is a specialized and advanced educational program designed to prepare individuals for specific careers or professions requiring high expertise, skill, and knowledge. These programs typically follow the completion of a bachelor's degree and are oriented toward professional development and specialized training. While the learning process depends on learners' abilities and dedication, hospitals need to support medical specialty trainees to ensure that they can demonstrate what is expected in good medical practice and achieve the learning outcomes required by their curriculum.

The hospital shall develop and implement a professional graduate education program that includes at least the following:

- a) Clear curriculum and assessment requirements.
- b) An educational induction program to make sure that trainees understand their curriculum.
- c) Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum.
- d) The opportunity to work and learn with other members of medical staff to support interprofessional multidisciplinary working.
- e) Regular, useful meetings with clinical and educational supervisors

When assessments are required, they should be mapped to the requirements of the approved curriculum and appropriately sequenced to match students' progression through their education and training. Someone with appropriate expertise in the area being assessed shall carry out assessments and shall be trained to use a variety of objective assessment tools for evaluating the trainees.

Survey process guide:

- GAHAR surveyor may review the hospital's approved professional graduate education program.
- GAHAR surveyor may interview medical specialty trainees and their clinical and educational supervisors to assess postgraduate curricula, assessment processes, educational activities, and records.
- GAHAR surveyor may review postgraduate curricula and educational activities records.

Evidence of compliance:

1. The hospital has an approved program that includes all the points in the intent from a) through e).
2. Medical specialty trainees are oriented to and comply with medical staff rules and regulations, hospital policies, and procedures.
3. Medical specialty trainees comply with policies and procedures of the hospital.
4. Educators are trained to use objective assessment tools for evaluating the trainees.

Related standards:

ATH.06 Activities of house officers and residents, ATH.03 Curriculum development, WFM.10 Medical Staff Structure.

Equitable and efficient research program

ATH.08 The hospital establishes an ethical framework for research activities.

Patient-centeredness

Keywords:

Research Ethical Framework

Intent:

As research ethics are the primary concern, hospitals usually assign the responsibility of ethically reviewing research protocols and their supporting documents to a committee.

Approval or disapproval is based on the ethical acceptability of the research, including its social value and scientific validity, an acceptable ratio of potential benefits to risks of harm, the minimization of risks, adequate informed consent procedures (including cultural appropriateness and mechanisms to ensure voluntariness), measures to ensure protection of vulnerable populations, fair procedures for selection of participants, and attention to the impact of research on the communities from which participants will be drawn, both during the study and after it is complete. The review considers any prior scientific reviews and applicable laws.

The Research Ethics Committee (REC) shall be established according to a charter or other document that establishes the manner in which members and the chairman will be appointed. The hospital shall support REC with an adequate number of trained staff to enable it to carry out its technical and administrative responsibilities with sufficient resources for the staff to fulfill its assigned functions, including office space and equipment and supplies (e.g., computers, stationery, telephones,

photocopying machines, shredding machine) to perform administrative business, to store committee files, and to keep documents secure and confidential.

Support includes access to appropriate space for the committee to meet, adequate means for members to communicate as needed between meetings, and adequate financial resources to permit the committee to produce high-quality work.

The hospital shall ensure committee members are trained on the role and responsibilities of the REC, the full range of ethical considerations relevant to research with human participants, fundamental aspects of research methodology and design (for members who lack such background), the impact of different scientific designs and objectives on the ethics of a research study; and the various approaches for recognizing and resolving the tensions that can arise among different ethical considerations and modes of ethical reasoning.

Survey process guide:

- GAHAR surveyor may interview hospital leaders and some committee members to inquire about research activities.
- GAHAR surveyor may review committee structure documents, meeting agenda, meeting minutes, and meeting notes.

Evidence of compliance:

1. The hospital ensures that the research ethics committee has a multidisciplinary membership and includes individuals with backgrounds relevant to the research areas.
2. The hospital supports the committee with resources, including staffing, facilities, and financial resources.
3. The committee sets minimum requirements for approval of research protocols.
4. The committee approves all research protocols that involve human subjects as required by law and regulation.

Related standards:

OGM.15 Ethical management, PCC.08 Informed consent.

ATH.09 Patient rights are protected during research activities.

Patient-centeredness

Keywords:

Research Patient Rights

Intent:

In ethically acceptable research, risks have been minimized and are reasonable in relation to the potential benefits of the study. The nature of the risks may differ according to the type of research to be performed; harm may occur either at an individual level or at the family or population level. Enrolment in a research experiment might carry uncertainty and fear to participants. Also, withdrawal from it might make the participants fearful of being discriminated against.

Invasions of privacy and breaches of confidentiality are disrespectful to participants and can lead to feelings of loss of control or embarrassment, as well as tangible harms such as social stigma, rejection by families or communities, or lost opportunities such as employment or housing. The ethical foundation of informed consent is the principle of respect for persons. Competent individuals are entitled to choose

freely whether to participate in research and to make decisions based on an adequate understanding of what the study entails.

The hospital shall develop and implement a research policy and procedures that includes at least:

- a) Eligibility for enrolment in research projects or protocols.
- b) Patient rights during research enrolment.
- c) Confidentiality guarantees for photographs and patient information included in the research.
- d) The patient has the right to withdraw from the research experiment without fear of retribution.

No one should be deprived of their fair share of the benefits of research; these benefits include the direct benefits of participation (if any) as well as the new knowledge that the study is designed to yield.

Informed consent should be taken; decisions for children or adults who lack the mental capacity to provide informed consent should be made by an authorized surrogate decision-maker.

Survey process guide:

- GAHAR surveyor may interview hospital leaders and some committee members to inquire about research activities.
- GAHAR surveyor may interview patients enrolled in research activities to ensure their rights are respected during research enrolment.
- GAHAR surveyor may interview researchers to check their awareness of research activities requirements.
- GAHAR surveyors may review the research file and the medical records of patients who participated in research activities to check for signed patient consent.

Evidence of compliance:

1. The hospital has an approved policy that includes all the points in the intent from a) through d).
2. Researchers are aware of the policy requirements.
3. Signed patient consent for participation in research is placed in the research file and the patient's medical record.
4. When patient safety issues are identified during research, patients are informed, and actions are taken to ensure patient safety.

Related standards:

PCC.02 Patient and family rights, PCC.08 Informed consent, PCC.13 Patient's dignity, privacy, and confidentiality, IMT.08 Patient's Medical record Management.

Survey Activities and Readiness

Introduction:

- GAHAR survey process involves performing building tours, observations of patient's medical records, staff member files, credential files, and interviews with staff and patients.
- The survey is an information gathering activity to determine organization's compliance with the GAHAR standards.

Readiness Tips:

- To facilitate the completion of the survey within the allotted time, all information and documents should be readily available for the surveyors to review during survey
- If certain staff members are missing, the team will continue to perform the survey; the appropriate missing staff members may join when they are available.
- Files may be in paper or in electronic format; however, the information should, at all times, be safe and secure from unauthorized access, up-to-date, accessible, and readily retrievable by authorized staff members.

	Activity	Timeframe	Location in survey agenda
1	Arrival and Coordination	30-60 minutes	1st day, upon arrival
2	Opening Conference	15 minutes	1st day, as early as possible
3	Hospital Orientation	30-60 minutes	1st day, as early as possible
4	Survey Planning	30-60 minutes	1st day, as early as possible
5	Document Review Session	60-180 minutes	
6	Patient Journey Tracer	60-120 minutes	Individual Tracer activity occurs throughout the survey; the number of individuals who surveyors trace varies by organization
7	Break	30 minutes	At a time negotiated with the organization Team Meeting/Surveyor Planning
8	Daily Briefing	15-30 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary
9	Staff members file review	30-60 minutes	After some individual tracer activity has occurred; at a time negotiated with the hospital
10	Environment and facility safety plans review	45-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the hospital
11	Environment of care evaluation tour	60-240 minutes	After document review
12	Leadership interview	60 minutes	During early or middle of survey
13	Financial Stewardship Review	60 minutes	After leadership interview

	Activity	Timeframe	Location in survey agenda
14	Patient's medical record review	60-120 minutes	Towards the end of survey
15	Medication Management Review	60-120 minutes	In the middle of survey
16	Infection Prevention and Control Review	60-120 minutes	In the middle of survey
17	Quality Program Review	60 minutes	Towards the end of survey
18	Report Preparation	60-120 minutes	Last day of survey
19	Executive Report	15 minutes	Last day of survey
20	Exit Conference	30 minutes	Last day, final activity of survey

Arrival and coordination

Why will it happen?

To start survey process on time, GAHAR surveyors shall use the time to review the focus of the survey in the light of submitted application

What will happen?

GAHAR surveyors shall arrive to the hospital and may present themselves to hospital security or desk. Hospital survey coordinator shall be available to welcome GAHAR surveyors

How to prepare?

Identify a location where surveyors can wait for organization staff to greet them and a location where surveyors can consider as their base throughout the survey.

The suggested duration of this step is approximately 30 to 60 minutes. Surveyors need a workspace they can use as their base for the duration of the survey. This area should have a desk or table, internet and phone coverage, and access to an electrical outlet, if possible. Provide the surveyors with the name and phone number of the survey coordinator

Who should collaborate?

Suggested participants include hospital staff and leaders

Opening conference

Why will it happen?

This is an opportunity to share uniform understanding of the survey structure, answer questions about survey activities and create common expectations

What will happen?

GAHAR surveyors shall introduce themselves and describe each component of the survey agenda. Questions about the survey visit, schedule of activities, availability of documents or people and any other related topics should be raised at this time.

How to prepare?

Designate a room or space that will hold all participants and will allow for an interactive discussion. Who should collaborate?

Suggested participants include members of the governing body and senior leadership. Attendees should be able to address leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your organization's mission and strategic objectives.

Hospital orientation

Why will it happen?

GAHAR surveyors shall learn about the hospital through a presentation or an interactive dialogue to help focus subsequent survey activities

What will happen?

Hospital representative (usually hospital director or his/her designee) shall present information about the hospital

How to prepare?

Prepare a brief summary (or a presentation) about the hospital that includes at least information about:

- Hospital mission, vision, and strategic goals
- Organization structure and geographic locations
- Information management, especially the format and maintenance of medical records
- Contracted services
- Compliance with general safety requirements.
- Summary of Community involvement
- Hospital's patient population, most common 5 diagnoses and most common 5 procedures
- Whether the hospital has any academic, research or transplantation activities
- Whether the hospital provides any home care or services outside the boundaries of hospital facility
- Compliance to GAHAR reports and recommendations during the pre-accreditation visit period

Who should collaborate?

Suggested participants include the same participants as the Opening Conference.

Survey planning

Why will it happen?

To ensure efficiency of survey time

What will happen?

Surveyors shall begin selecting patients for tracers based on the care, treatment, and services the hospital provides How to prepare?

Survey coordinator need to ensure that the following information are available for surveyors

- List of sites where deep or moderate sedation is in use
- List of sites where high-level disinfection and sterilization is in use
- List of departments/units/ areas/programs/services within the hospital, if applicable
- List of patients that includes: name, location, age, diagnosis, and length of stay, admit date, point of admission
- Lists of scheduled surgeries and special procedures, e.g. cardiac catheterization, endoscopy lab, electroconvulsive therapy, caesarian sections, including location of procedure and time

Who should collaborate?

GAHAR surveyors only.

Document review session

Why will it happen?

To help GAHAR surveyors understand hospital operations

What will happen?

GAHAR surveyors shall review required policies (or other quality management system documents) and policy components based on GAHAR standards

How to prepare?

Survey coordinator shall ensure that all valid current and approved quality management system documents are available for review either in paper or electronic format (approval should be visible, clear and authentic)

Use of bookmarks or notes is advisable to help surveyors find the elements being looked for

- 1) List of unapproved abbreviations
- 2) Performance improvement data from the past 12 months
- 3) Documentation of performance improvement projects being performed, including the reasons for performing the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes)
- 4) Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being performed (including reasons for performing the projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping
- 5) Analysis from a high-risk process
- 6) Emergency Management Policy
- 7) Emergency management protocols
- 8) Annual risk assessment and Annual Review of the Program
- 9) Assessment-based, prioritized goals
- 10) Infection Control surveillance data from the past 12 months

Who should collaborate?

Survey coordinator and policy stakeholders

Patient journey tracer

Why will it happen?

Patient journey tracer are defined as an assessment, made by surveyors shadowing the sequential steps of a patient's clinical care, of the processes in an organization that guide the quality and safety of care delivered (Greenfield et al., 2012a: 495).

GAHAR surveyors shall follow course of care and services provided to the patient to assess relationships among disciplines and important functions and evaluate performance of processes relevant to the individual

What will happen?

- The tracer process takes surveyors across a wide variety of services.
- The tracer methodology's use of face-to-face discussions with healthcare professionals, staff members and patients, combined with review of patient's medical records and the observations of surveyors
- Quality, timeliness of entries and legibility of recording in patient's medical record is also crucial to safe, effective care because healthcare professionals rely on it to communicate with each other about treatment needs and decisions
- This shall help guide surveyors as they trace a patient's progress.
- The individual tracer begins in the location where the patient and his/her medical record are located. The surveyor starts the tracer by reviewing a file of care with the staff person responsible for the individual's care, treatment, or services. The surveyor then begins the tracer by following the course of care, treatment, or services provided to the patient from preadmission through post discharge, assessing the interrelationships between disciplines, departments, programs, services, or units (where applicable), and the important functions in the care, treatment or services provided which may lead to identifying issues related to care processes

- Most of GAHAR standards can be triggered during a patient journey tracer activity which may also include interviewing staff, patients or family members
 - Staff members may be interviewed to assess organization processes that support or may be a barrier to patient treatment and services, Communications and coordination with other staff members, Discharge planning, or other transitions-related resources and processes available through the hospital, Awareness of roles and responsibilities related to the various policies
 - Patients or family members may be interviewed to assess coordination and timeliness of services provided, Education, including discharge instructions, Perception of care, treatment or services, Understanding of instructions (e.g., diet or movement restrictions, medications, discharge and healthcare professional follow-up), as applicable

How to prepare?

- Every effort needs to be exerted to assure confidentiality and privacy of patients during tracers including no video or audio recording and no crowdedness
- A surveyor may arrive in a department and need to wait for staff to become available. If this happens, the surveyor may use this time to evaluate environment of care issues or observe the care, treatment, or services being assessed.
- All efforts will be done to avoid having multiple tracers or tours in the same place at the same time.

Who should collaborate?

Survey Coordinator and any staff member (when relevant)

Break

Why will it happen?

To allow time for surveyor and for hospital staff to use the information learned What will happen?

GAHAR surveyor shall meet in their base alone How to prepare?

- Make sure that the place is not going to be used during the break time Who should collaborate?
GAHAR surveyors only.

Daily briefing

Why will it happen?

GAHAR surveyor shall summarize the events of the previous day and communicate observations according to standards areas

What will happen?

GAHAR surveyors briefly summarize the survey activities completed the previous day.

GAHAR surveyors shall make general comments regarding significant issues from the previous day and note potential noncompliance, with a focus on patient safety.

GAHAR surveyors shall allow time to provide information that they may have missed or that they requested during the previous survey day.

*Note: Hospital staff may present to surveyors information related to corrective actions being implemented for any issues of non-compliance. Surveyors may still record the observations and findings.

How to prepare?

- A room shall be available to accommodate all attendees

Who should collaborate?

Suggested participants include representative(s) from governance, Hospital Director, Hospital leaders, individual coordinating the GAHAR survey, and other staff at the discretion of hospital leaders

Staff members file review

Why will it happen?

The review of files, in itself, is not the primary focus of this session; however, the surveyor shall verify process-related information through recorded in staff member's files. The surveyor shall identify specific staff whose files they would like to review.

What will happen?

- GAHAR surveyor may ensure that a random sample of staff files is reviewed.
- The minimum number of records selected for review is 5 staff member files
- If findings are observed during the file review, the survey team may request additional file samples to substantiate the findings recorded from the initial sample.
- Throughout the review process, if a big number of findings are observed, the survey team may document whether the findings constitute a level of non-compliance
- The total number of records within the six-month case period Should be recorded on the review form.
- Surveyor may focus on orientation of staff, job responsibilities, and/or clinical responsibilities, Experience, education, and abilities assessment, Ongoing education and training, performance evaluation, credentialing and privileging, and competency assessment

How to prepare?

- The hospital shall produce a complete list of all staff members including outsourced, contracted, full-timers, fixed-timers, part-timers, visitors, volunteers, and others

Who should collaborate?

Representatives from medical management, nursing management and human resources management teams

Environment and facility safety plans review

Why will it happen?

GAHAR surveyor may assess the hospital degree of compliance with relevant standards and identify vulnerabilities and strengths in the environment and facility safety plans

What will happen?

There shall be a group discussion. Surveyors are not the primary speakers during this time; they are listeners to the discussion. the surveyor shall review the Environment of Care risk categories as indicated in the hospital risk assessment and safety data analysis and actions taken by the hospital.

How to prepare?

Make sure that those responsible for environment and facility safety plans are available for discussion Also, the following documents have to be available

- Hospital licenses, or equivalent
- An organization chart
- A map of the organization, if available
- List of all sites that are eligible for survey
- Environment and facility safety data
- Environment and facility safety Plans and annual evaluations
- Environment and facility safety multidisciplinary team meeting minutes prior to survey
- Emergency Operations Plan (EOP) and documented annual review and update, including communications plans
- Annual training

Who should collaborate?

Environment and facility safety responsible staff members such as safety management coordinator, security management coordinator, facility manager, building utility systems manager, information technology (IT) representative, and the person responsible for emergency management.

Environment of care tour

Why will it happen?

GAHAR surveyor observes and evaluate the hospital actual performance in managing environment and facility risks.

What will happen?

GAHAR surveyor may Begin where the risk is encountered, first occurs or take a top-down/bottom up approach.

GAHAR surveyor may interview staff to describe or demonstrate their roles and responsibilities for minimizing the risk, what they are to do if a problem or incident occurs, and how to report the problem or incident

GAHAR surveyor may assess any physical controls for minimizing the risk (i.e., equipment, alarms, building features), Assess the emergency plan for responding to utility system disruptions or failures(e.g., alternative source of utilities, notifying staff, how and when to perform emergency clinical interventions when utility systems fail, and obtaining repair services), assess If equipment, alarms, or building features are present for controlling the particular risk, reviewing implementation of relevant inspection, testing, or maintenance procedures

GAHAR surveyor may also assess hazardous materials management, waste management, safety or security measures.

How to prepare?

Ensure that keys, communication tools and contacts are available, so GAHAR surveyor may be able to access all hospital facilities smoothly

Who should collaborate?

Environment and facility safety responsible staff members such as safety management coordinator, security management coordinator, facility manager, building utility systems manager, information technology (IT) representative, and the person responsible for emergency management.

Leadership interview

Why will it happen?

The surveyor will learn about hospital governance and management structure and processes

What will happen?

GAHAR surveyor addresses the following issues

- The structure and composition of the governing body
- The functioning, participation, and involvement of the governing body in the oversight and operation
- The governing body's perception and implementation of its role in the hospital
- Governing body members understanding of performance improvement approaches and methods
- Pertinent GAHAR Leadership standards relevant to the governing body, direction and leadership in the hospital including organization culture
- Surveyors may explore, through hospital-specific examples, Leadership commitment to improvement of quality and safety, creating a culture of safety, Robust process improvement and Observations that may be indicative of system-level concerns

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with hospital leaders The following documents may be reviewed during this session

- Hospital structure
- Hospital strategic plan
- Hospital ethical framework
- Governing Body minutes for the last 12 months
- Leadership safety rounds
- Patient centeredness initiatives Medical Staff Bylaws and Rules and Regulations
- Medical Executive Committee meeting minutes
- Peer Review process and results
- Who should collaborate?

Required participants include at least the following: hospital director, governing body representative, clinical responsible leaders, Human resources management leader, performance improvement coordinator

Financial stewardship review

Why will it happen?

The surveyor will learn about hospital financial stewardship structure and processes

What will happen?

GAHAR surveyor addresses topics related to financial stewardship such as observations noted during hospital tours and tracers, billing process, contractor's performance, availability of staff, supplies and equipment

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with financial stewardship representatives

The following documents may be reviewed during this session

- List of all contracted services
- Agreement with outside blood supplier, referral laboratory, radiology, and other services
- Contractor monitoring data
- Feedback reports from payers
- Financial audit schedules, focus and major findings

Who should collaborate?

Required participants include at least the following: hospital director, procurement responsible leader, clinical responsible leader, finance responsible leader

Patient's medical record review

Why will it happen?

The review of files, in itself, is not the primary focus of this session; however, the surveyor verifies process-related information through recording in patients' medical records. The surveyor identifies specific patients whose files they would like to review.

What will happen?

- GAHAR surveyor may ensure that a random sample of patient's medical record is reviewed.
- A sample of both open and closed cases Should be reviewed. Record review should include a random sample from each of active and discharged cases.
- The sample selected represents a cross section of the cases performed at the hospital.
- If findings are observed during the file review, the survey team may request additional file samples to substantiate the findings recorded from the initial sample.
- Throughout the review process, if a big number of findings are observed, the survey team may document whether the findings constitute a level of non-compliance
- The total number of records within the six-month case period Should be recorded on the review form.

How to prepare?

- The hospital is required to produce a log or other record of closed cases for the previous sixmonth period and the surveyor will select a sample of medical records to review.

Who should collaborate?

Representatives from hospital medical, nursing, and other healthcare teams in addition to information management representatives.

Medication management review

Why will it happen?

GAHAR surveyor will Learn about the planning, implementation, and evaluation of medication management program, identify who is responsible for its day-to-day implementation, evaluate its outcome and Understand the processes used by the hospital to reduce medication errors and antibiotics stewardship

What will happen?

GAHAR surveyor will evaluate hospital medication management systems by performing system tracers. Discussions in this interactive session with staff include:

- The flow of the processes, including identification and management of risk points, integration of key activities and communication among staff/units involved in the process with a focus on management of high-risk medications, look-alike sound-alike, concentrated electrolytes and medication errors
- Strengths in the processes and possible actions to be taken in areas needing improvement; with a special focus on:
 - Antimicrobial Stewardship including: A document that describes how the hospital uses Antibiotic Stewardship Program, Hospital-approved antimicrobial stewardship protocols (e.g. policies, procedures or order sets are acceptable), Antimicrobial stewardship multidisciplinary team
 - Process for reporting errors, system breakdowns, near misses, or override, Data collection, analysis, systems evaluation, and performance improvement initiatives

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with staff who oversee the medication management program. Then time may be spent where the medication is received, stored, dispensed, prepared, or administered

The following documents may be reviewed during this session

- Medication management policies
- Core Elements of Hospital Antibiotic Stewardship Programs
- Antimicrobial stewardship data
- Antimicrobial stewardship reports documenting improvement

Who should collaborate?

Suggested participants include clinical and support staff responsible for medication management processes.

Infection prevention and control program review

Why will it happen?

GAHAR surveyor will Learn about the planning, implementation, and evaluation of infection prevention and control program, identify who is responsible for its day-to-day implementation, evaluate its outcome and Understand the processes used by the hospital to reduce infection

What will happen?

GAHAR surveyor will evaluate hospital IPC systems by performing system tracers. Discussions in this interactive session with staff include:

- The flow of the processes, including identification and management of risk points, integration of key activities and communication among staff/units involved in the process; How individuals with infections are identified, Laboratory testing and confirmation process, if applicable, Staff orientation and training activities, Current and past surveillance activity - Strengths in the processes and possible actions to be taken in areas needing improvement; Analysis of infection control data, Reporting of infection control data, Prevention and control activities (for example, staff training, staff vaccinations and other health-related requirements, housekeeping procedures, organization-wide hand hygiene, food sanitation, and the storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment), staff exposure, Physical facility changes that can impact infection control and Actions taken as a result of surveillance and outcomes of those actions.

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with staff who oversee the infection prevention and control process. Then time is spent where the care is provided The following documents may be reviewed during this session

- Infection prevention and control policies
- Infection control education and training records
- Infection control measures data

Who should collaborate?

Suggested participants include the infection control coordinator; physician member of the infection control team; healthcare professionals from the laboratory; Safety management staff; organization leadership; and staff involved in the direct provision of care, treatment, or services.

Activity quality program review

Why will it happen?

GAHAR surveyor will Learn about the planning, implementation, and evaluation of quality management program, identify who is responsible for its day-to-day implementation, evaluate its outcome and Understand the processes used by the hospital to reduce risks

What will happen?

Discussions in this interactive session with staff include:

- The flow of the processes, including identification and management of risk points, integration of key activities and communication among staff/units involved in the process; - Strengths in the processes and possible actions to be taken in areas needing improvement; Use of data
- Issues requiring further exploration in other survey activities;
- A baseline assessment of standards compliance.

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with staff who oversee the quality management program. Then time may be spent where improvement was implemented The following documents may be reviewed during this session

- Quality management program
- Performance Improvement projects

- Performance management measures ▪ Risk Management registers, records and logs

Who should collaborate?

Suggested staff members include quality management staff, healthcare professionals involved in data collection, aggregation and interpretation, performance improvement teams

Report preparation

Why will it happen?

To provide an opportunity of clarification and consolidation of any findings

What will happen?

Surveyors use this session to compile, analyze, and organize the data collected during the survey into a report reflecting the hospital compliance with the standards.

Surveyors may also ask organization representatives for additional information during this session How to prepare?

- GAHAR surveyors may need a room that includes a conference table, power outlets, telephone, and internet coverage.

Who should collaborate?

GAHAR surveyors only.

Executive report

Why will it happen?

To give an opportunity to brief the most relevant outcomes of the survey and help prioritization of post-accreditation activities

What will happen?

GAHAR surveyors will review the survey findings with the most senior leader and discuss any concerns about the report

How to prepare?

- GAHAR surveyor may need a quiet private area for brief interactive discussion with the most senior leader

Who should collaborate?

Hospital available most senior leader and others at his/her discretion

Exit conference

Why will it happen?

To thank the hospital team for participation and share the important findings in the accreditation journey

What will happen?

Surveyors will verbally review the survey findings summary, if desired by the most senior leader and review identified standards compliance issues

How to prepare?

- Hospital available most senior leader may invite staff to attend, an area that can accommodate attending staff is required

Who should collaborate?

Suggested participants include the hospital available most senior leader (or designee), senior leaders and staff as identified by the most senior leader or designee.

Glossary

- 1- **ABC analysis:** The analysis of annual medication consumption and cost in order to determine which items account for the greatest proportion of the budget.
- 2- **Adherence to medication:** The degree to which the person's behavior corresponds with the agreed recommendations from a healthcare professional.
- 3- **Adverse drug event (ADE):** This is an injury resulting from medication intervention related to a drug .
- 4- **Adverse drug reaction (ADR):** A response to a medication which is noxious and unintended, and which occurs at doses normally used in Human for the prophylaxis, diagnosis, or therapy of disease, or for restoration, correction, or for the modifications of physiological and psychological function
- 5- **Airborne Infection Isolation:** (AIIRs), commonly called negative pressure rooms, are single occupancy patient care spaces designed to isolate patients with airborne pathogens.
- 6- **Airborne:** They are particles $\leq 5\mu$ in size that remain suspended in the air and travel great distances.
- 7- **Ancillary services:** are supportive or diagnostic measures that supplement and support a primary physician, or other healthcare provider in treating a patient. Some examples of ancillary services include Imaging tests (e.g., X-rays, MRI, CT scan, ultrasound).
- 8- **Antimicrobial stewardship:** Is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.
- 9- **Antiseptics:** They are substances that reduce or stop the growth of potentially harmful microorganisms on the skin and mucous membranes. Or Antimicrobial substances that are applied to the skin to reduce the number of microbial flora.
- 10- **Appointment:** The process of reviewing an initial applicant's credentials to decide if the applicant is qualified to provide patient care services that the hospital's patients need and that the hospital can support with qualified staff and technical capabilities
- 11- **Aseptic technique:** It is a method designed to reduce the risk of microbial contamination in a vulnerable body site. This may include procedures like undertaking a wound dressing or performing an invasive procedure such as inserting a urinary catheter or preparing an intravenous infusion.
- 12- **Beyond use date:** The date or time after which a compounded sterile preparation (CSP) or compounded nonsterile preparation (CNSP) may not be stored or transported or used and are calculated from the date or time of compounding.

- 13- Cardiopulmonary resuscitation:** An emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped. It involves giving strong, rapid pushes to the chest to keep blood moving through the body. Usually, it also involves blowing air into the person's mouth to help with breathing and send oxygen to the lungs. Also called CPR.
- 14- Certification:** The procedure and action by which an authorized organization evaluates and certifies that a person, institution, or program meets requirements.
- 15- Cleaning:** It is the process of removing foreign material (e.g. soil, organic material, micro-organisms) from an object.
- 16- Clinical pharmacist:** Clinical pharmacists work directly with physicians, other health professionals, and patients to ensure that the medications prescribed for patients contribute to the best possible health outcomes. Clinical pharmacists practice in healthcare settings where they have frequent and regular interactions with physicians and other health professionals, contributing to better coordination of care.
- 17- Clinical practice guidelines:** Statements that help healthcare professionals and patients choose appropriate healthcare for specific clinical conditions (for example, recommendations on the case management of diarrhea in children under the age of five years). The healthcare professional is guided through all steps of consultation (questions to ask, physical signs to look for, lab exams to prescribe, assessment of the situation, and treatment to prescribe).
- 18- Cognitive Behavioral Therapy (CBT):** is a form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders, and severe mental illness
- 19- Competence or competency:** A determination of the staff's job knowledge, skills, and behaviours to meet defined expectations. Knowledge is the understanding of facts and procedures. Skill is the ability to perform specific actions, behaviours, such as the ability to work in teams, are frequently considered as a part of competence.
- 20- Community initiative:** A community initiative can be an individual or network of individuals dedicated to improving the health and welfare of a community. All community-based initiatives have the common objective of achieving health for all through health and development interventions.
- 21- Community partners:** means all external entities that partner with the Authority and enter into formal agreement with the Authority to conduct outreach or enrollment assistance, whether or not they are funded or compensated by the Authority.
- 22- Contaminate:** textile that has been solid with blood or other infectious materials (OSHA definition).

- 23- Contamination:** The presence of unwanted material or organism, such as an infectious agent, bacteria, parasite, or another contaminant, that is introduced to an environment, surface, object, or substance, such as water, food, or sterile medical supplies.
- 24- Contingency management (CM):** the systematic reinforcement of desired behaviors and the withholding of reinforcement or punishment of undesired behaviors, is an effective strategy in the treatment of alcohol and other drug (AOD) use disorders.
- 25- Credentialing:** The process of obtaining, verifying, assessing, and attesting the qualifications of a physician. The process determines if a staff member can provide patient care services in or for a healthcare organization. The process of periodically checking the physician's qualifications is called re-credentialing.
- 26- Credentials:** Documents that are issued by a recognized entity to indicate completion of requirements or the meeting of eligibility requirements, including education (such as a diploma from a medical school, specialty training completion letter or certificate, completion of the requirements of a medical professional organization, licensure, recognition of registration with a medical or dental council, training, and experience, which indicate the individual's sustainability to fulfil a role.
- 27- Curriculum development:** The term curriculum refers to individual and collective lessons, academic content, and materials used to reach grade-level content goals and standards. Curriculum development is the complex process large publishing firms, school districts, and teachers use to write lessons, create assessments, and select appropriate materials and resources for each unit or chapter in each subject area.
- 28- Defined daily dose (DDD)** The assumed average maintenance dose per day for a medication used for its main indication in adults.
- 29- Days of therapy (DOT):** The number of days that a patient received an antimicrobial agent (regardless dose)
- 30- Didactic teaching:** "didactics" refers to the science of teaching (in relation to aims, subject matter, methods, and frameworks) within a specific field. Didactics is based on multiple theories of teaching, and in a wider sense, theory and the practical application of teaching and learning methods.
- 31- Discharge summary:** A section of the patient's medical record that summarizes the reasons for hospitalization, significant findings, procedures performed, treatment rendered, patient's condition on discharge, and any specific instructions given to the patient or family
- 32- Disinfectants:** they are substances that are applied to the surface of non-living objects in order to destroy microorganisms but not necessarily bacterial spores.
- 33- Disinfection:** It is the process of reducing the number of pathogenic microorganisms, but not necessarily bacterial spores to a level which is no longer harmful to health. It may be high level, intermediate level or low level disinfection depending on the level of probable risk.

- 34- Dispensing:** preparing, packaging, and distributing to a patient a course of therapy on the basis of a prescription.
- 35- Droplet:** it is a large respiratory particle $\geq 5\mu$, which is generated when an infected person coughs, sneezes, or talks, or during procedures such as suctioning, endotracheal intubation, cough induction by chest physiotherapy or cardiopulmonary resuscitation; with possible transmission within 2 meters from the patient source.
- 36- Drug and therapeutic committee (DTC):** The committee that evaluates the clinical use of medications, policies for managing pharmaceutical use and administration and manages the formulary system
- 37- Drug Formulary:** A manual containing a clinically oriented summary of pharmacological information about a selected number of medications. The manual may also include administrative and regulatory information pertaining to medication prescribing and dispensing.
- 38- Epidemic:** an unexpected increase in the number of disease cases in a specific geographical area.
- 39- Evidence-Based Practice:** A way of providing health care that is guided by a thoughtful integration of the best available scientific knowledge with clinical expertise. This approach allows the practitioner to critically assess research data, clinical guidelines, and other information resources in order to correctly identify the clinical problem, apply the most high-quality intervention, and re-evaluate the outcome for future improvement.
- 40- Expired medication:** is one that is past the expiry date listed on the original packaging from the manufacturer.
- 41- External:** Refers to the outside of the organization, such as comparing data with other organizations or contributing to Egypt's required database.
- 42- Failure mode and effects analysis (FMEA):** A systematic approach to examining a design prospectively for possible ways failure may occur. The ways failure may occur are then prioritized to help organizations create design improvements that shall have the most benefit. This tool assumes that no matter how knowledgeable or careful people are, errors shall occur in some situations and may even be likely to occur.
- 43- Formulary:** A formulary contained a collection of formulas for the compounding and testing of medication (a resource closer to what would be referred to as a pharmacopeia today). Today, the main function of a prescription formulary is to specify particular medications that are approved to be prescribed at a particular organization, in a particular health system, or under a particular health insurance policy. The development of prescription formularies is based on evaluations of efficacy, safety, and cost-effectiveness of medications. Depending on the formulary, it may also contain additional clinical information, such as side effects, contraindications, and doses. The hospital formulary list should be according to the national essential medicines list.

- 44- Governing body:** The individual(s) or group that has ultimate authority and responsibility for developing policy, maintaining the quality of care, and providing for organization management and planning for the organization.
- 45- Hand hygiene:** A general term that applies to handwashing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.
- 46- Handover:** The transfer of responsibility for a patient and patient care that occurs in the healthcare setting. For example, in the hospital from one healthcare professional to another, from one level of care to another level, from an inpatient unit to a diagnostic or another treatment unit, and from staff to patients/families at discharge.
- 47- Hazardous materials and waste management plan:** The hospital written document that describes the process it would implement for managing the hazardous materials and waste from source to disposal. The plan describes activities selected and implemented by the hospital to assess and control occupational and environmental hazards of materials and waste (anything that can cause harm, injury, ill-health, or damage) that require special handling. Hazardous materials include radioactive or chemical materials. Hazardous wastes include the biologic waste that can transmit disease (for example, blood, and tissues), radioactive materials, toxic chemicals, and infectious waste, such as used needles and used bandages.
- 48- Head of department:** The staff member who manages and directs the subgroups of the organization, commonly referred to as departments, services, units, or wards.
- 49- Healthcare Practitioner:** a clinical practitioner refers to a qualified healthcare professional who provides direct patient care, including assessment, diagnosis, treatment, and ongoing management of health conditions. Clinical practitioners can include physicians, nurses, nurse practitioners, physician assistants, and other allied health professionals involved in direct clinical care.
- 50- Healthcare Professional:** a healthcare professional is an individual who is trained and licensed to provide medical, nursing, dental, pharmaceutical, or allied healthcare services to patients or communities. Healthcare professionals work in diverse roles and settings, including hospitals, clinics, community health centers, and public health organizations.
- 51- HEPA filter:** High-efficiency particulate air filter is defined as a filter with efficiency of 99.97% in removing particles 0.3 microns or more in size, which makes it suitable for prevention of airborne pathogens.
- 52- High-risk medication:** Medications that bear a heightened risk of causing significant patient harm when they are used in error.
- 53- Hospital director (chief executive of the organization):** A job as a hospital director falls under the broader career that plan, direct, or coordinate medical and health services in hospitals, clinics, managed care organizations, public health agencies, or similar organizations.
- 54- Hospital-Acquired Infection (HAI):** Any infection(s) acquired by a patient while receiving care or services in a healthcare organization. Common HAIs are urinary infections, surgical wound infections, pneumonia, and bloodstream infections.

- 55- Hygiene:** The practice that serves to keep people and environments clean and prevent infection.
- 56- Immunization:** is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine (active immunisation) or serum containing desired antibodies (passive immunisation). Vaccines stimulate the body's own immune system to protect the person against subsequent infection or disease, Infection control practitioner
- 57- Infection control program:** An organized system of services designed to meet the needs of the hospital in relation to the surveillance, prevention, and control of infection, which impacts patients, staff, physicians, and/or visitors.
- 58- Infection:** The transmission of a pathogenic microorganism.
- 59- Independent practitioners/Physician:** An Independent Physician is a physician who owns a majority of their practice and has key decision-making rights for the practice.
- 60- Intervention techniques:** minimally invasive procedures, including percutaneous precision needle placement, with placement of drugs in targeted areas.
- 61- Invasive procedure:** A medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Examples of invasive procedures include central line and chest tube insertions, and cardiac catheterization. Venipuncture is not categorized as an invasive procedure.
- 62- Inventory:** A written list of all the objects, abilities, assets, or resources in a particular place.
- 63- IPC committee:** The Infection Control Committee is generally comprised of members from a variety of disciplines within the healthcare facility; bringing together individuals with expertise in different areas of healthcare. It should be
- 64- Job description:** Statements or directions specifying required decisions and actions. Penalties, legal or otherwise, are normally assessed when laws and regulations are not followed.
- 65- Laws and regulations:** Statements or directions specifying required decisions and actions. Penalties, legal or otherwise, are normally assessed when laws and regulations are not followed.
- 66- Leader:** A person who sets expectations plans and implements procedures to assess and improve the quality of the hospital governance, management, clinical, and support functions and processes.
- 67- Legibility:** The possibility to read or decipher. The writing is clearly written so that every letter or number cannot be misinterpreted. It is legible when any ONE individual can read the handwritten documentation or physician order.

- 68- Look-alike Sound-Alike medications:** These are medications that are visually similar in physical appearance or packaging and names of medications that have spelling similarities and/or similar phonetics.
- 69- Medical staff:** professional who practices medicine, dentistry, and other independent practitioners.
- 70- Medical simulation:** defined as any educational activity that utilizes simulation aides to replicate clinical scenarios. Medical simulation allows the acquisition of clinical skills through deliberate practice rather than an apprentice style of learning.
- 71- Medication-Assisted Treatment (MAT):** is the use of medications, alongside counseling and behavioral therapies, to treat substance use disorders.
- 72- Mentorship programs:** are a type of professional development strategy organizations use to connect more experienced team members into developmental relationships with team members who want to expand their skills and/or experiences.
- 73- Minimum qualifications:** The minimum qualifications for a job are the absolute minimum requirements that a candidate must possess in order to be considered for the role. These qualifications may include, but are not limited to, specific skills, knowledge, experience, education, or licenses and certifications
- 74- Medication:** Any prescription medications including narcotics; herbal remedies; vitamins; nutraceuticals, over-the-counter medications; vaccines; biological, diagnostic and contrast agent used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood products; medication containing products, and intravenous solutions with electrolytes and/or medications. The definition of the medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases unless explicitly stated.
- 75- Medication / Drug recall:** is the most effective way to protect the public from a defective or potentially harmful product. A recall is a voluntary action taken by a company to remove a defective drug product from the market or warn patients and consumers about a potential risk.
- 76- Medication error:** Any preventable event that may cause inappropriate medication use or endangers patient safety. Examples are wrong patient, medication, dose, time, and the route; incorrect ordering, dispensing, or transcribing; missed or delayed treatments. Any professional/discipline/staff who handle medications can be involved in the error.
- 77- Medication reconciliation:** "the process of comparing a patient's medication orders to all of the medications that the patient has been taking
- 78- Medication sample:** A unit of a prescription medication that is not intended to be sold and is intended to promote the sale of the medication. A medication sample is given to the patient in very limited circumstances that should be defined in the hospital policy.

- 79- Medication therapy problem:** is an unwanted event or circumstance involving medication therapy that actually or potentially interferes with desired health outcomes.
- 80- N95 respirator:** it is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. The 'N95' designation means that when subjected to careful testing, the respirator blocks at least 95 percent of very small (0.3 micron) test particles.
- 81- Near miss:** is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so.
- 82- Net Promoter Score (NPS):** it measures customer loyalty by looking at their likelihood of recommending a given business. NPS score is measured with a single-question survey and reported with a number ranging from -100 to +100, where a higher score is desirable
- 83- Nonclinical staff:** Those who provide indirect patient care (hospitalization, food service, etc.)
- 84- Non-ionizing radiation:** Non-ionizing radiation is any kind of radiation in the electromagnetic spectrum that does not have enough energy to remove an electron from an atom and turn it into an ion, so Non-ionizing radiation can generate heat.
- 85- Nuclear medicine therapy:** uses radiopharmaceuticals targeting specific tumours, such as thyroid, lymphomas or bone metastases, delivering radiation to tumorous lesions as part of a therapeutic strategy to cure, mitigate or control the disease. It can be used either on selective targets or throughout the entire body
- 86- Ongoing professional practice evaluation (OPPE):** A well-designed process supports early detection and response to performance issues that could negatively impact patient outcomes.
- 87- Ordering:** is written directions provided by a prescribing practitioner for a specific medication to be administered to an individual. The prescribing practitioner may also give a medication order verbally to a licensed person such as a pharmacist or a nurse.
- 88- Outbreak:** An excess over the expected (usual) level of a disease within a geographic area; however, one case of an unusual disease may constitute an outbreak.
- 89- Outdated medication:** is one that is opened and is typically safe and effective to use for a short period of time after opening (shelf life)
- 90- Palliative Care:** is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.

- 91- Partogram:** A graphic recording of progress of labour and silent condition of the mother and fetus, has been used since 1970 to detect labour that is not progressing normally, to indicate when augmentation of labour is appropriate and to recognize cephalopelvic disproportion long before labour becomes obstructed.
- 92- Peer review:** A process whereby the performance of a hospital, staff or groups are evaluated by members of similar organizations or the same profession or discipline and status as those delivering the services.
- 93- Performance measures:** it is a quantifiable measure used to evaluate the success of a hospital, employee, etc.
- 92- Personal protective equipment (PPE):** it is equipment worn to minimize exposure to hazards that cause serious workplace injuries and/or illnesses.
- 93- Plan of care:** A plan that identifies the patient's care needs lists the strategy to meet those needs, records treatment goals and objectives, defined criteria for ending interventions, and records the patient's progress in meeting specified goals and objectives. It is based on data gathered during patient assessment.
- 94- Plan:** A detailed method formulated beforehand that identifies needs lists strategies to meet those needs, and sets goals and objectives. The format of the plan may include narratives, policies, and procedures, protocols, practice guidelines, clinical paths, care maps, or a combination of these.
- 95- Post-exposure prophylaxis:** it is a preventive medical treatment that is started after exposure to a pathogen in order to prevent the infection from taking place.
- 96- Practice guidelines:** Tools that describe processes found by clinical trials or by consensus opinion of experts to be the most effective in evaluating and/or treating a patient who has a specific symptom, condition, or diagnosis, or describe a specific procedure. Synonyms include practice parameters, protocol, preferred practice pattern, and guideline. Also, see evidence- (scientific) - based guidelines and clinical practice guidelines.
- 97- Prescribing:** advising and authorizing the use of a medication or treatment for someone, especially in writing.
- 98- Primary Source Verification (PSV):** Verification of an individual practitioner's reported qualifications by the original source or an approved agent of that source. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source, or reports from credentials verification organizations (CVOs)
- 99- Privileging:** The process whereby specific scope and content of patient care services (clinical privileges) are authorized for a healthcare professional by the organization, based on the evaluation of the physician's credentials and performance.

100- PRN: Latin abbreviation Pro re nata Frequently used to denote whenever necessary or As needed.

101- Procedure: a series of steps to be followed as a uniform and repetitive approach to accomplish an end result. Procedures provide a platform for uniform implementation to decrease process variation, which increases procedure control. Decreasing process variation is how we eliminate waste and increase performance.

102- Process: A series of actions or steps taken in order to achieve a particular end.

103- Processing: All operations performed to render a contaminated reusable or single-use (disposable) device ready again for patient use. The steps may include cleaning and disinfection/sterilization. The manufacturer of reusable devices and single-use devices that are marketed as non-sterile should provide validated reprocessing instructions in the labeling.

104- Procurement: The process of acquiring supplies, including those obtained by purchase, donation, and manufacture. It involves efforts to quantify requirements, select appropriate procurement methods, and prequalify suppliers and products. It also involves managing tenders, establishing contract terms, assuring medications quality, obtaining the best prices, and ensuring adherence to contract terms.

105- Program: An organized, official system that guides action toward a specific goal. The program identifies needs, lists strategies to meet those needs, includes staff involved, and sets goals and objectives. The format of the program may include narratives, policies and procedures, plans, protocols, practice guidelines, clinical pathways, care maps, or a combination of these.

106- Project: A planned set of interrelated tasks to be executed over a fixed period and within certain cost and other limitations.

107- Protocol: A detailed scientific treatment plan for using a new treatment.

108- Radionuclide therapy: A type of radiation therapy in which a radionuclide (a radioactive chemical) is linked to a cell-targeting molecule, such as a monoclonal antibody, and injected into the body.

109- Referral: The sending of a patient from one clinician to another clinician or specialist or from one setting or service to another or another resource

110- Respiratory hygiene: This comprises infection prevention measures designed to limit the transmission of respiratory pathogens spread by droplet or airborne routes.

111- Restrain: is when a person is held to stop them moving their body. Mechanical restraint is when items are used, such as tying belts or straps on their hands or arms. Physical restraint is when staff use their hands or body to stop a person moving freely.

112- Risk assessment: The identification and evaluation of potential failures and sources of errors in a process. This is followed by prioritizing areas for improvement based on the actual or potential impact on care, treatment, or services provided.

- 113- Root cause analysis:** A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.
- 114- Safe injection:** It is a practice intended to prevent needle stick injuries and other possible contamination during syringe introduction in a patient; ultimately preventing transmission of blood borne infectious diseases between one patient and another, or between a patient and a healthcare professional.
- 115- Sanitation:** it is a condition concerning public health, especially indicating provision of clean drinking water, and adequate sewage disposal.
- 116- Scope (care or services):** The range and type of services offered by the hospital and any conditions or limits to the service coverage.
- 117- Scope of practice:** The range of activities performed by a healthcare professional (physician, nurse) in the organization. The scope is determined by training, tradition, law or regulation, or the organization.
- 118- Safety Data Sheets(SDSs):** The SDS includes information such as the properties of each chemical; the physical, health, and environmental health hazards; protective measures; and safety precautions for handling, storing, and transporting the chemical.
- 119- Seclusion:** is when a person is placed alone in a room and cannot leave by themselves. An example is a room with a door that locks and unlocks from the outside.
- 120- Sentinel event:** A patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm, or severe temporary harm.
- 121- Seroconversion:** The production of antibodies (proteins) in the blood of a person who did not have the antibodies before. It occurs after vaccination or exposure to a virus or other substance. Testing for seroconversion can be used to look for the presence of an infection or disease or to see how well the body's immune system responds to a vaccine.
- 122- Side effect:** The pharmacological effect of a medication, normally adverse, other than the one(s) for which the medication is prescribed.
- 123- Single-use device Also referred to as a disposable device:** it is intended for use on one patient during a single procedure. It is not intended to be reprocessed (cleaned and disinfected or sterilized) and used on another patient. Using disposable items improves patient safety by eliminating the risk of patient-to-patient contamination because the item is discarded and not used on another patient (According to the Food and Drug Administration).
- 124- Stakeholders:** An individual or group that is involved in and affected by a policy or course of action. In health care, stakeholders may include patients and their families; physicians, nurses, and other clinicians and practitioners; nonclinical staff members; members of leadership and governance; vendors and contracted employees; members of the community; and others.

- 125- Systematic reviews:** Type of literature review of research which require equivalent standards of rigour as primary research. They have a clear, logical rationale that is reported to the reader of the review. They are used in research and policymaking to inform evidence-based decisions and practice.
- 126- Spaulding classification:** it is a method of classification of the different medical instrumentation based on device usage and body contact into three categories, critical, semi-critical and non-critical dictated by the infection risk involved by using it.
- 127- Sterilization:** a process that destroys or eliminates all forms of microbial life and is carried out in health-care facilities by physical or chemical methods
- 128- Stock:** A quantity of something accumulated, as for future use, regularly kept on hand, as for use or sale; staple; standard.
- 129- Surveillance:** A systemic and ongoing method of data collection, presentation and analysis, followed by dissemination of that information to those who can improve outcomes.
- 130- Tapering:** is defined as the gradual discontinuation or reduction of a therapeutic dose of a particular medication over a period of time.
- 131- Terminally ill:** is having an advanced stage of a disease with an unfavorable prognosis and no known cure.
- 132- Therapeutic duplication:** One person using two medications, usually unnecessarily, from the same therapeutic category at the same time.
- 133- Timeliness:** The time between the occurrence of an event and the availability of data about the event. Timeliness is related to the use of the data.
- 134- Titrating order:** Orders in which the medication dose is progressively increased or decreased in response to the patient's status.
- 135- Transcribing:** the legitimate copying of prescription information from one source to another without any alterations or additions
- 136- Transmissible:** it is a disease with the ability to be passed on from one person or organism to another.
- 137- Utilization:** The use, patterns of use, or rates of use of specified healthcare service. Overuse occurs when a healthcare service is provided under circumstances in which its potential for harm exceeds the possible benefits. Underuse is the failure to use a necessary healthcare service when it would have produced a favorable outcome for a patient. Misuse occurs when an appropriate service has been

selected, but a preventable complication occurs. All three reflect a problem in the quality of healthcare. They can increase mortality risk and diminish the quality of life.

- 138- Variation:** The differences in results obtained in measuring the same event more than once. The sources of variation can be grouped into two major classes common causes and special causes. Too much variation often leads to waste and loss, such as the occurrence of undesirable patient health outcomes and increased cost of health services.
- 139- VEN analysis:** A known method to help set up priorities for purchasing medications and keeping stock. Medications are divided according to their health impact into vital, essential, and nonessential categories. It allows medications of differing efficacy and usefulness to be compared.
- 140- Vendor:** A person or representative of a company that has a contract with the hospital and/or is seeking to provide support, services, or maintenance for a company's product(s) or service(s).

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