GAHAR Handbook for

PRIMARY HEALTHCARE PROVISIONAL ACCREDITATION STANDARDS

2025 Edition

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Introduction

The ultimate goal of healthcare is to provide high-quality healthcare services to all who need them in a suitable manner and at the appropriate time. The quality of healthcare depends on the level of value that healthcare facilities provide to all their stakeholders within the scope of their services. The provisional accreditation requirements for Primary healthcare facilities in 2025 come as part of a set of publications by the General Authority for Healthcare Accreditation and Regulation, as part of affirming the efforts of all state agencies and institutions to move forward towards achieving Egypt's Vision 2030 and its goals, especially the advancement of the quality of life of the Egyptian citizen and achieving justice in rights and opportunities. This is achieved by achieving an acceptable level of quality in healthcare and human safety in all PHCs in Egypt. The provisional accreditation requirements for Primary healthcare in 2025 rely on four main axes: basic requirements, GAHAR safety requirements, Essential quality requirements, and The operating manual. It also relies in its reference primarily on the relevant laws and regulations in Egypt's Vision 2030, as well as the standards of the General Authority for Healthcare Accreditation and Regulation for Primary healthcare 2025, submitted to be accredited by the International Society for Quality in Healthcare (ISQua) in December 2024. It should be noted that obtaining provisional accreditation according to these requirements is the main step towards reaching the larger and more important stage in achieving the quality of healthcare, which is obtaining accreditation according to Primary healthcare standards 2025

Provisional Accreditation System for Healthcare Facilities

Within the framework of the successive and continuous steps taken towards organizing the health sector to ensure its safety, stability, and improvement of its quality, and to affirm confidence in the quality of healthcare outputs in the Arab Republic of Egypt at all local, regional, and international levels; the Board of Directors of the General Authority for Healthcare Accreditation and Regulation has decided the following:

First: Setting the rules and conditions for the provisional accreditation of healthcare facilities as a prelude to their accreditation by the Authority, which includes, but is not limited to, the following:

a) Achieving the basic requirements for healthcare facilities.
b) Achieving **G**AHAR **S**afety **R**equirements (GSR) in healthcare facilities to ensure the safety of patients, companions, visitors, and employees of these facilities.
c) Achieving essential quality requirements to ensure the efficiency and effectiveness of healthcare services and the satisfaction of beneficiaries of the service.
d) Achieving the requirements of an operating manual for the healthcare facility to achieve a stable professional performance of the facility in all its departments and at all levels of service provision at all times and in all cases.

Second: Facilities that have obtained provisional accreditation from the Authority are committed to applying for the Authority's accreditation within a maximum period of three years from the date of the governorate's entry into the implementation of the universal health insurance law or three years from the date of provisional accreditation for facilities in governorates that have not entered the scope of the law's application, as of the date of provisional accreditation, otherwise the provisional accreditation shall be considered null and void.

Third: The duration of the provisional accreditation of the facility shall be one calendar year, renewable in accordance with the provisions of the previous paragraph.

Fourth: The General Authority for Healthcare Accreditation and Regulation shall define and raise awareness among the concerned parties about the procedures for the provisional accreditation of healthcare facilities according to a specific and comprehensive plan that does not in any way conflict with any of the rules governing the principles of transparency and avoiding conflicts of interest.

Fifth: Provisional accreditation requirements for PHCs:

a) Basic requirements.
b) GAHAR safety requirements.
c) Essential quality requirements.
d) Operating manual.

Sixth:

The provisional accreditation of the facility shall be according to the scope of services provided with the application for provisional accreditation. The authority must be notified in writing of any change in the scope of services provided (adding a new service, canceling an existing service, or increasing the volume of an existing service by more than 20%) via email to reg@gahar.gov.eg at least **one month** before implementing this change.

Seventh:

In the Case of sentinel event, the General Department for Registration and Accreditation of Healthcare Facilities must be notified within 48 hours of its occurrence or notification via email to

Sentinel.Event@gahar.gov.eg. The General Department for Registration and Accreditation must be provided with a root cause analysis of the reasons for the occurrence of the sentinel event within a maximum period of 45 days from the date of the occurrence of the sentinel event or notification thereof (as defined in standard QPI.07, page 233), attached to the corrective action plan to prevent/reduce its recurrence according to the nature of the event.

Eighth:

The facility is obligated to register at least 30% of the total number of medical professionals before the evaluation visit, and the remaining registration must be completed within three months from the date of provisional accreditation.

Ninth:

The provisional accreditation of the facility will be suspended for a period not exceeding six months in the following cases:

1. There were sentinel events related to the safety of patients, employees, or visitors that were not reported to GAHAR as stated in paragraph (Seventh).
2. Failure of the provisionally accredited facility to pass an unannounced evaluation visit in accordance with the decision-making rules.
3. Non-compliance with the data of the provisionally accredited facility in the provisional accreditation application and the current status of the facility during unannounced evaluation visits.
4. Failure to notify to GAHAR of any change in the scope of services provided (adding a new service, canceling an existing service, or increasing the volume of an existing service by more than 20%) at least one month before implementing this change.
5. Incompliance with of the basic registration requirements.
6. Incompliance with the provisions of paragraph (Eighth).

Tenth:

Without violation of o the provisions of Law No. 2 of 2018, the provisional accreditation of the facility may be cancelled in the following cases:

1. Discovery of any tampering or forgery during or after the evaluation process or proof of the inaccuracy of the documents attached and submitted by the facility.
2. Obstruction by the facility of the work of Health regulation team, such as obstructing the obtaining of documents and data related to the field of health regulation work or access to places and services within the scope of auditing and inspection.
3. The facility's failure to pass the second chance visit in the case of conditional provisional accreditation.
4. Refusal of the provisionally accredited facility to receive the surveyors in announced/unannounced evaluation visits.
5. Cancellation of the facility's license or issuance of an administrative decision or court ruling to close it temporarily or permanently.
6. Transfer of the facility from its location stated in the provisional accreditation form or in the event of demolition or reconstruction of the facility.
7. Exceeding the specified period for suspending provisional accreditation as stated in paragraph (Ninth) without correcting the reasons for suspending provisional accreditation.

Steps for Provisional Accreditation of a Healthcare Facility at the General Authority for Healthcare Accreditation and Regulation:

1. The facility submits a provisional accreditation application to the authority by completing and submitting the designated form.
2. The General Authority for Healthcare Accreditation and Regulation reviews the application submitted by the facility and responds with a statement outlining the requirements and fees for the provisional accreditation of that facility.
3. The applicant facility pays the provisional accreditation fees and submits the necessary documents to the General Authority for Healthcare Accreditation and Regulation in accordance with the provisional accreditation requirements stated in the authority's response in the previous step.
4. the General Authority for Healthcare Accreditation and Regulation reviews the documents received from the facility, verifies their completeness, and contacts the facility to complete and correct any documents that the authority deems necessary to complete the provisional accreditation process.
5. After ensuring that all required documents in step (3) are complete, the General Authority for Healthcare Accreditation and Regulation schedules a visit to the facility to verify and audit the structure and processes related to the documents submitted by the facility.
6. A team of surveyors conducts an evaluation visit to the facility.

Provisional Accreditation Renewal:

- If the facility that has obtained provisional accreditation does not apply for accreditation within the first year from the date of acceptance of the provisional accreditation, it has the right to request a renewal of the provisional accreditation for another year, provided that the time period is calculated starting from the date of the provisional accreditation of the facility (if it was not from the governorates that entered the scope of applying the comprehensive health insurance system) or the date of entry of the governorate to which the facility belongs into the comprehensive health insurance system.
- According to Law No. 2 of 2018, facilities whose provisional accreditation with the authority has expired are evaluated for re-provisional accreditation for an additional period(s) of up to three years from the date of the governorate's entry into the scope of implementing the comprehensive health insurance law or from the date of the first provisional accreditation with the General Authority for Healthcare Accreditation and Regulation (whichever is earlier).

General Requirements:

1. The facility is committed to the accuracy of the documents and data submitted at all stages of the provisional accreditation process. If it is proven that the submitted documents are inaccurate at any stage of the visit, the facility is subject to cancellation of the evaluation visit.
2. The facility is committed to not using any certificate or logo of the authority in a misleading manner.
3. The facility is committed to not providing misleading data that harms the provisional accreditation certificate issued by the General Authority for Healthcare Accreditation and Regulation.

4. The General Authority for Healthcare Accreditation and Regulation is committed to informing the facility of the decision within a period not exceeding 15 working days from the date of completion of the evaluation work.
5. The General Authority for Healthcare Accreditation and Regulation has the right to inform the community of the results of the provisional accreditation, its suspension, or cancellation, as required by Law No. 2 of 2018.

Look Back Period

Surveyors are required to review the PHC's compliance with the Provisional Accreditation Requirements over a look back period.

A look back period is the period before the survey visit during which any PHC should comply with the Provisional Accreditation Requirements. Failure to comply with this rule shall affect the Provisional Accreditation decision.

A PHC seeking initial Provisional Accreditation should comply with Provisional Accreditation requirements for at least **one month** before the surveyors' visit.

PHC seeking Re-Provisional Accreditation should comply with Provisional Accreditation requirements for the whole period from the initial Provisional Accreditation till the Re- Provisional Accreditation survey.

Scoring System

Scoring of Basic Requirements

PHCs are either compliant or noncompliant with the basic requirements. The compliance is assessed before the survey.

The noncompliance may result in being non-eligible for GAHAR Provisional Accreditation/ accreditation survey.

Scoring of GAHAR Safety Requirements (GSRs), and Essential Quality Requirements (EQRs)

During the survey visit, each GSR/EQR is scored for the evidence of compliance (EOC). These are mathematical rules that depend on summation and percentage calculation of scores of each EOC as follows:

- **Met:** when the PHC shows 80% or more compliance with requirements during the required lookback period with a total score of 2.
- **Partially met:** when the PHC 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 PHC 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 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.

Example:

Evidences of compliance of GSR.01:

1. The PHC has an approved policy guiding patient identification that addresses all elements mentioned in the intent from a) through C).
2. All healthcare professionals are aware of the PHC policy.
3. Patient identification occurs according to the policy.

In this example, 2nd and 3rd evidences of compliance are dependent on the 1st one.

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 but not less than 50%.
- **Not met:** when the average score of the applicable EOCs of this standard is less than 50%.
- **Not applicable:** when the surveyor determines that all EOCs are not applicable.

Scoring of the Operating Manual

Surveyors review random sample of at least 10 documents other than those required for GSRs and EQRs to evaluate the percentage of the minimum contents covered in the operating manual

(when applicable) as follows:

- **Met:** when the PHC shows 80% or more compliance with the minimum contents with a total score of 2.
- **Partially met:** when the PHC shows less than 80% but more than or equal to 50% compliance with the minimum contents with a total score of 1.
- **Not met:** when the PHC shows less than 50% compliance with the minimum contents with a total score of 0.
- **Not applicable:** when the surveyor determines that, the requirements are out of the organization scope (the score is deleted from the numerator and denominator)

NB. Only approved current documents are considered valid for evaluation.

Overall scoring

Relative weight of different sections:

- GSRs constitute 45% of the total score.
- EQRs constitute 45% of the total score.
- Operating manual constitutes 10% of the total score.

Provisional Accreditation Decision Rules

1st Decision: Status of Provisional Accreditation for one year

- Compliance to basic requirements, and
- Overall compliance of the 3 requirements' sections (section 2 to section 4) is 80% or more, and
- Compliance score of each individual section of the 3 requirements' sections (section 2 to section 4) is not less than 80%, and
- No single GAHAR safety requirement (whole standard) is scored not met.

2nd Decision: Status of Provisional Accreditation that requires passing the 2nd survey visit within 9 months (Conditioned Provisional Accreditation)

- Compliance to basic requirements, and
- Overall compliance of the 3 requirements' sections (section 2 to section 4) is 70% to less than 80%, or
- Compliance score of each individual section of the 3 requirements' sections (section 2 to section 4) is 70% to less than 80%, or
- No more than one GAHAR safety requirement (whole standard) is scored not met.

NB. The PHC can be Provisionally Accredited under terms and conditions of "conditioned Provisional Accreditation" only once.

3rd Decision: Status of Provisional Accreditation that requires passing the 2nd survey visit within 6 months (Conditioned Provisional Accreditation).

- Compliance to basic requirements, and
- Overall compliance of the 3 requirements' sections (section 2 to section 4) is 60% to less than 70%, or
- Compliance score of each individual section of the 3 requirements' sections (section 2 to section 4) is 60% to less than 70%, or
- No more than two GAHAR safety requirements (whole standards) are scored not met.

NB. The PHC can be Provisionally Accredited under terms and conditions of "conditioned Provisional Accreditation" only once.

4th Decision: Denial of Provisional Accreditation

- Non-compliance to basic requirements, or
- Overall compliance of the 3 requirements' sections (section 2 to section 4) is less than 60%, or
- Compliance score of each individual section of the 3 requirements' sections (section 2 to section 4) is less than 60%, or
- More than two GAHAR safety requirements (whole standards) are scored not met, or

- The presence of any imminent life-threatening situation that is detected by the survey team and agreed upon by the accreditation committee.

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 PHCs 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.

  - Document versus Record

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

- Physician Versus Medical staff member

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

► Reading and Interpretation of handbook

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 two main sections: GSRs and EQRs l in addition to Basic requirements and operating manual.

- GSRs and EQRs contains various standards.
- 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, and evidence of compliance.

Standard components

- Standard statement:
  Each standard is written as a standard statement preceded by a code.
  Each standard is followed by a non-black-scripted statement that describes the essential quality dimension(s) addressed by the standard
- Keywords:
  The standard keywords are meant to help PHCs understand the most important element(s) of standard statements, as these are words or concepts of great significance. Keywords answer the question of what the standard is intended to measure.
- Intent:
  The intent is meant to help PHCs 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 PHCs 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.
- Survey process guide:
  Facilitates and assists the surveyors in the standards' ratings for the required EOCs.

- Evidence of compliance (EOC):
  - The EOC 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.

Section 1: Basic Requirements

Reading and Interpretation of Basic Requirements

- For an organization seeking GAHAR Provisional Accreditation/Re-Provisional Accreditation and accreditation/re-accreditation, compliance with the basic regulatory requirements are submitted to reg@gahar.gov.eg. to be assessed before the on-site survey.
- This section consists of basic regulatory requirements for participation in the GAHAR Provisional Accreditation process as an initial step for GAHAR full accreditation.

Compliance to current relevant laws and regulations and their updates as follows:

Governmental PHC

1. Hazardous Waste Handling License
2. Ionizing Radiation Equipment License
3. Civil Defense Compliance Certificate
4. Elevator License
5. Electrical Generator License

Non-Governmental PHC

1. PHC License
2. Hazardous Waste Handling License
3. Pharmacy License
4. Laboratory License
5. Ionizing Radiation Equipment License
6. Civil Defense Compliance Certificate
7. Elevator License.
8. Electrical Generator License.

N.B. For reference, please check the annex.

Section 2: GAHAR Safety Requirements

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 GAHAR accreditation process, PHCs have to show commitment to patient safety. This requires compliance with each of GAHAR Safety Requirements (GSRs).

During surveys, surveyors evaluate that safe and efficient implementation of each of GSRs is maintained in all relevant practices. The application of the standards should be according to the applicable laws and regulations.

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.

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.11**
GSR.03	Critical results	**ICD.22**
GSR.04	Fall screening and prevention	**ICD.07**
	Diagnostic and Ancillary Services	
GSR.05	Radiation Safety Program	**DAS.04**
GSR.06	Laboratory Safety Program	**DAS.09**
	SURGICAL AND INVASIVE PROCEDURAL SAFETY	
GSR.07	Surgical site marking	**SIP.03**
GSR.08	Pre-operative checklist	**SIP.04**
GSR.09	Timeout	**SIP.05**
	MEDICATION MANAGEMENT AND SAFETY	
GSR.10	High-risk medications	**MMS.06**
GSR.11	Look-alike and sound-alike medication	**MMS.07**
GSR.12	Medication reconciliation, best possible medication history (BPMH)	**MMS.09**
GSR.13	Medication storage, medication labelling, multiple dosing medication	**MMS.04**
	ENVIRONMENTAL AND FACILITY SAFETY	
GSR.14	Fire and smoke safety	**EFS.03**
GSR.15	Fire drills	**EFS.04**
GSR.16	Hazardous materials safety	**EFS.06**
GSR.17	Safety Management Plan	**EFS.07**
GSR.18	Medical Equipment Plan	**EFS.10**
GSR.19	Utilities Management Plan	**EFS.11**
	INFECTION PREVENTION AND CONTROL	
GSR.20	Hand Hygiene	**IPC.04**
	INFORMATION MANAGEMENT AND TECHNOLOGY	
GSR.21	Use of symbols, and abbreviations	**IMT.03**

GENERAL PATIENT SAFETY

GSR.01 ACT.03 Accurate patient identification using at least two identifiers to identify the patient

Safety

Keywords:

Patient identification

Intent:

Providing care or performing interventions on the wrong patient are significant errors which may have grave consequences.
Using two unique identifiers for each patient is the key driver in minimizing such preventable errors, which is especially important with the administration of medication or dealing with clinical specimens, radiological, and invasive procedures.
The PHC shall develop and implement a policy and procedures to guide the process of patient identification. The policy shall address at least the following:

a) Two unique identifiers (personal).
b) Occasions when verification of patient identification is required.
c) Special situations when patient identification may not follow the same process, such as for unidentified victims of accidents in emergency situations.

Survey process guide:

- GAHAR surveyor may review the PHC policy guiding the process of patient identification.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the PHC policy and ensure their usage of at least two unique patient identifiers before procedures such as invasive procedures.
- GAHAR surveyor may review a sample of medical records to check the presence of the two identifiers mentioned in the policy in each sheet.

Evidence of compliance:

1. The PHC has an approved policy guiding patient identification that addresses all elements mentioned in the intent from a) through c).
2. All healthcare professionals are aware of the PHC policy.
3. Patient identification occurs according to the policy.
4. Patient identifiers are recorded in the patient's medical record.
5. The PHC monitors the reported data on patient's identification process and takes actions to control or improve the process as appropriate.

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

Safety

Keywords:
Verbal and telephone orders

Intent:

Miscommunication is the most common root cause of 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 PHC shall develop and implement a policy and

procedures for receiving verbal and telephone communication. The policy shall address at least the following:

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

Evidence of compliance:

1. The PHC has an approved policy for 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 orders and telephone orders are recorded in the patient's medical record within a predefined timeframe.
4. The PHC monitors the reported data of verbal and telephone orders and takes actions to control or improve the process as appropriate.

GSR.03 ICD.22 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 and medical imaging service shall define 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 PHC shall develop and implement a policy and procedures to guide the process of identifying and reporting critical results. The policy shall address 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. The mean of notification.
   ii. Date and time of notification.
   iii. 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 policy of critical results to check whether it clearly describes the process of recording and read-back by the recipient.
- GAHAR surveyor may review recordings in used registers and/or patient's medical record.
- GAHAR surveyor may interview healthcare professionals to assess their awareness and compliance with PHC policy.

Evidence of compliance:

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

GSR.04 ICD.07 Patient's risk of falling is screened, assessed, and managed.

Safety

Keywords:

Fall screening 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 PHC shall develop and implement a policy and procedures to guide the fall screening and prevention process. The policy shall address at least the following:

a) Patient fall risk screening using appropriate tool.
b) Risks include medication review and other risk factors.
c) Timeframe to complete fall screening and assessment based on guidelines.
d) Frequency of reassessment of risk of fall when the patient stays in the PHC to receive further services.
e) General measures are used to reduce risk of falling such as lighting, corridor bars, bathroom bars, wheelchairs, or trolleys with locks.
f) Tailored care plans based on individual patient fall risk assessment.

Survey process guide:

- GAHAR surveyor may review the policy guiding the fall screening and prevention process.
- GAHAR surveyor may review a sample of patients' medical records, to check general measures and tailored care plans recording based on individual patient fall risk assessment.
- GAHAR surveyor may review medical records for fall risk assessment including medication review, fall prevention care plan forms, patient and family education material.
- GAHAR surveyor may interview healthcare professionals to check their awareness of PHC policy.
- GAHAR surveyor may interview patients and their families to check their understanding and implementation of fall risk assessment and prevention measures

- GAHAR surveyor may observe PHC- wide general preventive measures such as lighting, corridor bars, bathroom bars, wheelchairs and trolleys with locks.

Evidence of compliance:

1. The PHC has an approved fall screening and prevention policy to guide screening for patient's risk for fall includes all elements in the intent from a) through f).
2. Responsible staff is aware of the elements of approved policy.
3. Patients who have a higher level of fall risk and their families are aware of and involved in fall prevention measures.
4. All fall risk screening / assessments are completed and recorded in the patient medical record.
5. General measures and tailored care plans are recorded in the patient's medical record.

Diagnostic and Ancillary Services

GSR.05 DAS.04 The radiation safety program is developed and implemented.

Safety

Keywords:

Radiation safety program

Intent:

Radiation safety program provides information and training on the hazards, biological effects, and protective measures; develops policies by which radiological equipment are used safely; ensures compliance with regulations; and provides emergency response assistance. In specific cases, such as pregnant patients in the first trimester, even a single or slight exposure to radiation could be extremely harmful to the embryo. In pregnancy, radiological exposure could cause anomalies. Accordingly, radiation exposure is avoided unless there is no other way that could be used for diagnosis. The International Atomic Energy Authority standards affirm on highlighting the standards for imaging pregnant patients separately from the regular radiation protection standards. Warning signs in Arabic language and/or other warning symbols and warning red lights on the plain x-ray room shall be available in different areas for warning against accidental exposure to ionizing radiation for all, especially pregnant females or children.
When Medical Imaging services are provided on-site, environmental radiation safety measures, personal monitoring device results, and regular CBC results are available and monitored. The PHC shall develop and implement a program to guide the process of radiation safety to ensure the PHC environment, staff, patients, families, and vendors are safe from radiation hazards. It should be implemented, reviewed, and updated annually.

The program shall address at least the following:

a) Compliance with laws, regulations and guidelines.
b) All radiation equipment is maintained and calibrated.
c) Staff self-monitoring tools.
d) Staff suitable personal protective equipment.
e) Patients' radiation safety precautions.
f) Warning signs are posted clearly in different areas to avoid accidental exposure to ionizing radiation.

Survey process guide:

- GAHAR surveyor may review the radiation safety program to check compliance with laws and regulations, shielding methods, and safety requirements for both staff members and patients.

- GAHAR surveyor may review environmental radiation measures, thermos-luminescent dosimeter (TLD) and/or badge films of the staff results, CBC results, and lead aprons inspection.
- GAHAR surveyor may interview staff to check their awareness.
- GAHAR surveyor may observe medical imaging services inside the medical imaging area to check compliance with radiation safety precautions.

Evidence of compliance:

1. The PHC has a written, updated, and approved radiation safety program that addresses all elements mentioned in the intent from a) through f).
2. Staff members involved in medical imaging are aware of radiation safety precautions and receive ongoing training for new procedures and equipment.
3. Identified radiation safety risks are mitigated through processes, safety protective equipment, and devices for both staff and patients.
4. The PHC ensures that exposed patients do not exceed the approved maximum level according to local laws and regulations.
5. The PHC monitors the reported data on the radiation safety program, and it takes actions to control or improve the process as appropriate, at least quarterly.

GSR.06 DAS.09 A comprehensive laboratory safety program is developed and implemented.

Safety

Keywords:

Laboratory safety program

Intent:

The laboratory environment is a high-risk area where Laboratory staff members are exposed to numerous potential hazards, including chemical, biological, and physical 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. Laboratory safety program and laboratory risk assessment are performed, reviewed, and updated at least annually or upon introduction of new equipment, service, or change in lab procedures**.** The laboratory should have a documented program that describes the safety measures for laboratory facilities according to the national requirements. This program should be 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/biological) spills/spill clean-up.
i) Instructions for the use of personal protective equipment.

Survey process guide:

- The GAHAR surveyor may review the laboratory safety program, which should include at least: a 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 proper waste disposal.
- The 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 check their awareness regarding the laboratory safety Program.

Evidence of compliance:

1. A written updated program that describes safety measures for laboratory and laboratory services includes the items in the intent from a) through i).
2. Laboratory staff are trained on the laboratory safety program.
3. Staff are compliant with safety precautions according to the program**.**
4. Laboratory risk assessment is performed.
5. The PHC monitors the reported data on the laboratory safety program and takes actions to control or improve the process as appropriate.

SURGICAL AND INVASIVE PROCEDURAL SAFETY

GSR.07 SIP.03 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 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 PHC 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 and/or family
e) Surgeries and procedures exempted from site marking.
f) Appropriate time for surgical site marking before surgery / invasive procedure.
g) Monitoring compliance with the process.

Survey process guide:

- GAHAR surveyor may review the PHC policy guiding the site marking process.
- GAHAR surveyor may interview involved staff members to check their awareness of the PHC 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 PHC has an approved policy guiding the site marking process that includes at least elements from a) through g) mentioned in the intent.
2. Responsible staff are aware of the implementation of site marking.
3. Site marking is a unified mark all over the PHC and performed by the responsible physician for the invasive procedure.

4. The PHC monitors the reported data on site marking process and takes actions to control or improve the process as appropriate.

GSR.08 SIP.04 Documents and equipment needed for procedures 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 as results of the requested investigation or 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 cancellation of surgery or invasive procedure. Implementing regular check-ups is a quality improvement process that should be guided by designed checklists performed by trained staff. The PHC is required to ensure the availability and functioning of equipment needed for the invasive procedure before starting the procedure. This equipment and tools could be differed according to the type of invasive procedure. Also, the PHC is required to develop a process for preoperative verification of the availability of all needed or requested documents and other items before the patient going for the invasive procedure.

Survey process guide:

- GAHAR surveyor may interview involved staff to check their awareness of the PHC 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 investigations.
- GAHAR surveyor may review the document of endorsement and the checklist showing the availability and functioning of needed equipment.

Evidence of compliance:

1. The PHC has an approved process for preoperative verification of all needed documents and equipment
2. Responsible staff are trained on the PHC process for preoperative verification.
3. Recorded evidence of preoperative verification of all needed documents and equipment before each surgery or invasive procedure exists.
4. The PHC monitors the reported data on preoperative verification process and takes actions to control or improve the process as appropriate.

GSR.09 SIP.05 Correct patient, procedure, and body part is confirmed preoperatively and just before starting a surgical or invasive procedure (timeout).

Safety

Keywords:

Timeout

Intent:

Timeout for verification of the correct patient, correct surgery or invasive procedure, and correct site and side of invasive procedure is a single process that has been proved to reduce wrong-site surgery. When performing a surgery or invasive procedure, healthcare professionals should verify the right patient, the right

type of surgery, right site, right side, and the patient received the prophylactic antibiotic if applicable. The PHC shall develop and implement a policy and procedures to ensure correct patient, correct invasive procedure and correct site and side of invasive procedure and apply the time out process just before the start of the invasive procedure

Survey process guide:

- GAHAR surveyor may review the PHC 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.

Evidence of compliance:

1. The PHC has an approved policy to ensure the correct patient, procedure, and body part before surgical or invasive procedures.
2. Time out is implemented before surgery or invasive procedure starts.
3. The surgery or invasive procedure team is involved in the time out process, including the performing physician.
4. Timeout process is recorded in the patient’s medical record.

MEDICATION MANAGEMENT AND SAFETY

GSR.10 MMS.06 High-risk medications are identified, stored, and dispensed in a way that assures the risk is minimized.

Safety

Keywords
High-risk medications

Intent

High-risk medications are those bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these medications, the consequences of an error are clearly more devastating to patients. Examples of high-risk medications include, but not limited to, hypoglycemic agents, medications with narrow therapeutic range, and inotropic agents, etc.

The PHC shall develop and implement a policy and procedures to guide the process of safe use of high-risk medications. The policy shall address at least the following:

a) Lists of high-risk medications based on its own data and both nationally 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, including those that ensure the absence of concentrated electrolytes in PHC.

Examples of strategies to prevent errors may include:

- Separation from all other medications stored in the area.
- A system for regular checking and restocking at par level by pharmacy staff.
- The use of prominent warning labels/labeling system.

Survey process guide

- GAHAR surveyor may review the PHC policy that guides the process of safe use of high-alert medications.
- GAHAR surveyor may review the PHC high-risk list and check its availability.
- GAHAR surveyor may observe clinics and medication storage areas and assess measures/strategies implemented to ensure the safe storage of high-risk medications.
- GAHAR surveyor may interview staff members to assess their understanding of preventive strategies for managing these medications.

Evidence of compliance

1. The PHC has an approved high-risk medication management policy that addresses elements a) and b) in the intent.
2. The PHC provides training to the healthcare professionals involved in the management and use of high-risk medications.
3. The PHC has an approved and annually updated list(s) of high-risk medications.
4. The PHC implements process(es) to prevent inadvertent use of high-risk medications.
5. The PHC monitors the reported data on management of high-risk medications and takes actions to control or improve the process as appropriate.

GSR.11 MMS.07 Look-alike and sound-alike medications are identified, stored, and dispensed in a way that assures that risk is minimized.

Safety

Keywords
Look-alike and sound-alike medication

Intent

Look-alike and sound alike (LASA) medications are those visually similar in physical appearance or packaging and names of medications that have spelling similarities and/or similar phonetics. Any confusion between these medications may lead to harmful errors. The Institute for Safe Medication Practices (ISMP) maintains an ongoing list of LASA medication names to highlight medications that may require special safeguards. One strategy that ISMP recommends for reducing LASA medication errors is to include both the brand and non-proprietary names, dosage form, strength, directions, and the indication for use which can be helpful in differentiating LASA medication names. If LASA medications have different indications, then associating an indication with a medication may help differentiate it from another medication with a similar-sounding name. Other recommendations focus on ensuring prescription legibility through improved handwriting and printing. Some PHCs may use physical separation and segregation of these medications in medication storage areas to minimize the risk. In addition, some PHCs use specially designed labels or use "tall man" (mixed case) lettering (e.g., alDOMET and alDACTONE) to emphasize drug name differences. The PHC shall develop risk management strategies to minimize adverse events with LASA medications and enhance patient safety. The PHC shall develop and implement a policy and procedure to ensure the safety of LASA. The policy shall include at least the following:

a) List of Look-alike Sound-alike medications
b) Storage requirements
c) Labelling requirements
d) Dispensing requirements

Survey process guide

- GAHAR surveyor may review the PHC policy and the updated list of look–alike and sound-alike medications.
- GAHAR surveyor may interview healthcare providers to inquire about processes to minimize the risk associated with using look-alike sound-alike medications.
- GAHAR surveyor may observe the LASA medications segregation and labeling of different medication storage areas inside or outside the pharmacy.

Evidence of compliance

1. The PHC has an approved policy for managing look-alike and sound-alike medications that addresses all elements in the standard intent from a) through d).
2. The PHC has an approved and annually updated list(s) of look-alike and sound-alike medications.
3. The PHC provides training to the healthcare professionals involved in the management and use of LASA.
4. The PHC implements process(es) to prevent inadvertent use of LASA medications.
5. The PHC monitors the reported data on the management of LASA and takes actions to control or improve the process as appropriate.

GSR.12 MMS.09 Medications are reconciled across all interfaces of care in the PHC.

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 transitions in care where new medication(s) is/are ordered or existing order(s) is/are rewritten.
As a result, the new medication regimen prescribed at the time of receiving the service may inadvertently omit needed medications, unnecessarily duplicate existing therapies, or contain incorrect dosages. These discrepancies place patients at risk for adverse drug events (ADEs).
Medication reconciliation refers to the process of avoiding such inadvertent inconsistencies across transitions in care by reviewing the patient's complete medication regimen at the time of transition of care and comparing it with the regimen being considered (if any) for the new setting of care within predefined time frame.

The PHC develops and implements a policy and procedures to guide medication reconciliation process that addresses at least at least the following.

a) Situations where medication reconciliation is required.
b) Time frame within which medication reconciliation is done.
c) Determination of the responsibility of the healthcare professional involved in medication reconciliation.
d) Steps of the medication reconciliation process
   i. Developing/collecting and documenting a complete list of patient's current medications (both prescribed and non-prescribed (e.g., vitamins, nutritional supplements, over-the-counter medications, and vaccines) including those taken at scheduled time and those taken on as needed basis) at the beginning of the episode of care.
   ii. Developing a list of medications to be prescribed during episodes of care in the PHC.
   iii. Comparing the medications on both lists and making necessary decision(s) based on this comparison (whether the medications in the prescribed list and their dosages are appropriate) to avoid medication errors such as omissions, dosing errors, continuation of incorrect medications and duplications.

Survey process guide

- GAHAR surveyor may review the PHC policy, followed by interviewing healthcare providers to inquire about the medication reconciliation process.
- GAHAR surveyor may review a number of patient's medical records to assess the recording of current medication.
- GAHAR surveyor may interview with an appropriate number of patients to inquire about medication history assessment.
- GAHAR surveyor may check if patient's own medications are matching the recorded current medications and are included in the medication reconciliation process.

Evidence of compliance

1. The PHC has an approved policy for obtaining best possible medication history 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 medicationhistory (BPMH) and reconcile medications.

3. Medication prescriber identified by the PHC compares the list of current medications with the list of medications to be prescribed.
4. Reconciled medications are clearly recorded, and related information is clearly communicated to healthcare professionals involved in the patient's medication prescribing.

GSR.13 MMS.04 Medications are stored in a manner to maintain their security and quality

Safety

Keywords

Medication storage, medication labelling, multiple dosing medication

Intent

The stability/effectiveness of medications depends on storing them according to the manufacturer's recommendations at the correct conditions such as light, humidity and temperature. The PHC shall maintain appropriate storage conditions (temperature, light, humidity) in medication storage areas to protect the stability of medications during all time. This includes the storage and handling of multiple dosing medications.

The PHC 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 and to carry a regular inspection process to ensure the compliance with the required storage conditions.

Medications or other solutions in unlabelled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions being removed from their original containers and placed into unlabelled containers. Ensuring the labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications. Medications shall be labeled in a standardized manner. This requirement shall apply to any medication that is prepared but not administered immediately (this requirement does not apply to a medication prepared and administered immediately, e.g., in the emergency situations). At a minimum, labels shall include the following (if not apparent from the original package/box/container/ampoule/vial):

a) Medication name
b) Strength/concentration
c) Amount/quantity.
d) Expiration date
e) Beyond use date
f) Batch number.

Survey process guide

- GAHAR surveyor may observe the medication storage areas to assess storage conditions and labeling.
- GAHAR surveyor may observe at the labeling of multiple dosing medications (e.g., vaccines) showing the beyond use date.

Evidence of compliance

1. Medications are safely and securely stored according to manufacturer/marketing authorization holder recommendations in a clean, organized area.
2. The PHC has an approved process for the use and storage of multi-dose medications to ensure their stability and safety.
3. The PHC has a clear process to deal with an electric power outage to ensure the integrity of any affected medications before use.
4. Medication storage areas are periodically (at least monthly) inspected to confirm compliance with proper storage conditions.

5. All medications, medication containers, and other solutions in the PHC are clearly labeled (if not clearly shown on the original package/box/container/ampoule/vial) in a standardized manner with at least the elements from a) to f) in the intent.

ENVIRONMENTAL AND FACILITY SAFETY

GSR.14 EFS.03 Fire and smoke safety plan addresses prevention, alarm system response, and safe evacuation in case of fire and/or other internal emergencies.

Safety

Keywords:
Fire and smoke safety

Intent:

One of the critical considerations in the design for PHC is the prevention of fire, particularly with respect to the combustibility of construction and furnishing materials and the spread of fire and smoke.
In the event of either accidental or malicious fires; early detection (alarm system) and suppression equipment needs to be readily accessible to combat these fires.
Staff members of the PHC must be knowledgeable about equipment usage and communicate effectively based on previous arrangements and training.
Other internal emergencies may affect staff, patients, families, and vendors safety that may require evacuation when required and include but not limited to gas cylinder explosion, building collapse and swage leakage.
The PHC should perform Ongoing risk assessment of the PHC environment that include fire and smoke separation, areas under construction and other high-risk areas for example stores, laundry, oxygen supply storage areas, electrical control panels, medical records room, garbage room, etc. Risk mitigation measures are taken based on the fire risk assessment which should be updated annually.
The last resort, failing the ability to completely suppress the fire, is to evacuate the PHC. Moving all patients, visitors, and staff out of dangerous and/or damaged facilities as safely as possible is always the goal of an evacuation. With respect to priorities of evacuation of independent cases, then dependent cases by use of simple and available tools like mattresses, bed sheets, trolleys, wheelchairs, or other tools.
It is important to recognize that people's attention to detail and processes will not be optimal in an evacuation scenario. To that end, understanding key principles will help staff members make good decisions during a chaotic event.
The PHC develops a fire, smoke and non-fire safety plan based on environmental safety risk assessment that addresses at least the following:

a) Preventive measures that include at least the following:
    I. Assesses compliance with Civil Defence requirements and related laws and regulations.
    II. Safe storage and handling of highly flammable materials.
    III. Comply with no smoking policy according to laws &regulations.
    IV. Safe management of high-risk areas such as electric panels, and connections storage areas, fuel tanks and others.
b) fire alarm system, including the central control panel connected to all areas in PHC according to its functionality, and ensure continuous monitoring 24/7.
c) Regular inspection testing of early detection system & fire suppression systems.
d) Safe evacuation through availability of safe, unobstructed fire exits, with clear signage to assembly areas and emergency light, in addition to other related signages like how to activate the fire alarm, using a fire extinguisher and hose reel.

e) The PHC should perform proper training of all staff annually in a practical manner to make sure that everyone in the PHC can demonstrate RACE and PASS and other activities that keep the safety of all during fire and non-fire emergencies with documentation of all results regularly.

Survey process guide:

- GAHAR surveyor may review the fire safety plan, facility fire safety inspections, and fire system maintenance.
- GAHAR surveyor may check that fire alarm; firefighting and smoke containment systems are working effectively and complying with civil defence requirements.
- GAHAR surveyor may review the plan of testing (drills) and staff training (all staff should be trained on fire safety).

Evidence of compliance:

1. The PHC has an approved, updated fire and smoke safety plan that includes all elements from a) through e) in the intent.
2. All staff are trained on fire safety plans and can demonstrate their rules during fire or non-fire internal emergencies at least annually.
3. Fire risk assessment with risk mitigation measures are in place with corrective action when required.
4. The PHC fire alarm system is available, functioning, inspected, tested and maintained on a regular basis.
5. The PHC fire suppression system is available, functioning, inspected, tested and maintained on a regular basis.
6. Emergency exit doors and corridors are clearly signed and not obstructed.

GSR.15 EFS.04 Fire drills are performed in different PHC areas.

Safety

Keywords

Fire drills

Intent:

Fire drills are regular training exercises and simulations, aiming that all staff will gain a thorough understanding of the fire safety plan, enabling them to respond swiftly, safely, and in an orderly, confident manner during an emergency, including safely evacuating patients through the designated emergency exits.
To ensure staff preparedness for fire and other internal emergencies, regular drills are conducted at least quarterly, one of them at least is unannounced.
The PHC records fire drills details including, but are not limited to, the following:

a) Dates and timings consider Staff who participated in the drill.
b) Involved areas.
c) Shifts.
d) Corrective actions

Survey process guide:

- GAHAR surveyor may review the records of fire and evacuation drills with dates, timings, staff who participated, the involved areas in the PHC and corrective action plan based on the drill evaluation.
- GAHAR surveyor may Interview staff to check the awareness of fire safety plan and basic procedures in such cases like RACE and PASS (Rescue, Alarm, Confine, Extinguish/Evacuate and Pull, Aim, Squeeze, Sweep).

Evidence of compliance:

1. Fire drills are performed at least quarterly, including one unannounced drill.
2. All staff members participate in fire drills at least once annually.
3. Fire drill results are recorded from a) through d) in the intent.
4. Fire drill results evaluation is performed after each drill and corrective action plan when indicated.
5. The PHC staff guarantee Safe evacuation of patients, staff and visitors.

GSR.16 EFS.06 The PHC plans safe handling, storage, usage and transportation of hazardous materials and waste management.

Safety

Keywords:
Hazardous materials safety

Intent:
Hazardous materials are substances, which, if released or misused, can pose a threat to the environment, life or health. Industry, agriculture, medicine, research, and consumer goods use these chemicals.
Hazardous materials come in the form of explosives, flammable and combustible substances, poisons. These substances are most often released because of transportation accidents or chemical accidents in PHCs.
Because the effects of hazardous materials can be devastating and far-reaching, it is important that PHCs plan their safe use and establish a safe working environment.
PHC waste is any waste which is generated in the diagnosis, treatment, or immunization of human beings or in research in a PHC
Healthcare waste includes infectious, chemical, expired pharmaceutical and radioactive items and sharps. These items can be pathogenic and environmentally adverse. Other waste items generated through healthcare but not hazardous include medication boxes, the packaging of medical items and food, remains of food, and waste from offices.
PHC Waste Management means the management of waste produced by PHCs using such techniques that will help to check the spread of diseases.
The PHC should identify and control hazardous material and waste all over the PHC to ensure that staff, patients, families, and vendors, and the environment are safe.
Waste materials are categorized into the following categories according to the WHO classification:

I. Infectious
II. Pathological and anatomical
III. Pharmaceutical
IV. Chemical
V. Heavy metals
VI. Pressurized containers
VII. Sharps

Hazardous materials are classified according to the classification of hazardous chemicals. The Globally Harmonized System (GHS) categorizes chemicals into nine hazard classes in this following:

I. Flammable liquids
II. Oxidizers
III. Corrosives
IV. Toxic substances
V. Carcinogens
VI. Mutagens
VII. Reproductive toxins
VIII. Asphyxiants
IX. Explosives

Hazardous materials and waste management plan includes, but is not limited to, the following:

a) A current and updated inventory of hazardous materials used in the PHC according to the scope of services, the inventory should include the material name, hazard type, location, usage, consumption rate, and responsibility.
b) Safety data sheet (SDS) should be available and includes information such as physical data, hazardous material type (flammable, cytotoxic, corrosive, carcinogenic, etc.), safe storage, handling, spill management and exposures, first aid, and disposal.
c) Appropriate labelling of hazardous materials.
d) Procedure for safe usage, handling, and storage of hazardous materials.
e) Appropriate waste segregation, labelling, and storage,
f) Safe handling, transportation, and disposal of all categories of hazardous waste.
g) Availability of required protective equipment, spill kits, and eye washes.
h) Investigation and documentation of different incidents such as spill and exposure.
i) Compliance with laws and regulations, availability of required licenses, and/or permits
j) Staff training and orientation.
k) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review the hazardous material and waste management program to make sure that it covers all safety requirements of hazardous materials, safe storage, handling, spills, required protective equipment and waste disposal according to local laws and regulations.
- GAHAR surveyor may review the hazardous material and waste disposal plan, hazardous material, and waste inventories, as well as Safety Data Sheet (SDS).
- GAHAR surveyor may observe hazardous material labelling and storage in addition to waste collection, segregation, storage, and final disposal.

Evidence of compliance:

1. The PHC has a hazardous material and waste management plan that addresses all elements from a) through k) in the intent.
2. Staff is trained on hazards material and waste management.
3. The PHC ensures safe usage, handling, storage, availability of SDS and labelling of hazardous materials.
4. The PHC ensures safe handling, storage, and labelling of waste according to laws and regulations.
5. The PHC has a document for spill management, Investigation, and recording of different incidents related to hazardous materials.

GSR.17 EFS.07 A safe work environment plan addresses high-risk areas, procedures, risk mitigation requirements, tools, and responsibilities.

Safety

Keywords:
Safety Management Plan

Intent:
Health services are committed to providing a safe environment for staff, patients, families, and vendors. PHC safety arrangements keep patients, staff, and visitors safe from inappropriate risks such as electricity and from inappropriate behaviour such as violence and aggression.

The risk assessment shall be in place to identify potential risks because of system failure and/or staff behaviour, for example: wet floor; water leakage from the ceiling beside electrical compartments; unsecured electric panels, dealing with high voltage improper handling of sharps; non-compliance to personal protective equipment in a case dealing hazardous materials or exposure to spills or splash, availability of eye washer in high-risk area like the laboratory, and unsafe storage.

The PHC must have a safety plan with safety mitigation measures based on the risk assessment that covers the building, property, medical equipment, and systems to ensure a safe physical environment for patients, families, staff, visitors, and vendors.
The safety plan based on an environmental safety risk assessment that addresses at least the following:

a) Safety measures based on risk assessment, for example, infectious agents' exposure, electric, radioactive hazards, vibration and noise exposure.
b) Effective planning to prevent accidents and injuries and minimize potential risks, to maintain safe conditions for all occupants to reduce and control risks.
c) Processes for pest and rodent control.
d) Regular inspection with documentation of results, performing corrective actions, and appropriate follow-up.
e) Responsibilities according to laws and regulations.
f) Safety training on a general safety plan.
g) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review safety plan/s to make sure that they include suitable risk assessment surveillance.
- GAHAR surveyor may review the surveillance rounds plan. Checklist, different observations, and proper corrective actions when applicable.
- GAHAR surveyor may observe the safety measures implementation in all areas and safety instructions posters in all high-risk areas.
- GAHAR surveyor may inspect workers in different areas like workshops and waste collection areas to check usage of suitable personal protective equipment (PPE).

Evidence of compliance:

1. The PHC has an approved and updated plan to ensure a safe work environment that includes all elements from a) through g) in the intent.
2. Staff are trained on safety measures based on their jobs.
3. Risk mitigation is conducted based on risk assessment
4. Safety measures and PPEs are available and used whenever indicated.
5. Safety instructions are posted in all high-risk areas.

GSR.18 EFS.10 Medical equipment plan ensures selection, inspection, testing, maintenance, and safe use of medical equipment.

Safety

Keywords:
Medical Equipment Plan

Intent:

Medical equipment is critical to the diagnosis and treatment of patients.
In most PHCs, a trained biomedical staff manage the entire medical inventory and is responsible for dealing with medical equipment hazards. Not only does improper monitoring and management lead to inefficiency, but it can also seriously harm patient outcomes. As an example, poor maintenance increases the chances of downtime, and inadequate servicing and sterilization can be harmful to both

doctors and patients. This is why it is crucial to establish some basic equipment safety and service procedures according to the manual or contracted agent of the equipment.

The PHC develops a plan for medical equipment management that addresses at least the following:

a) Developing criteria for selecting new medical equipment.
b) Inspection and testing of new medical equipment upon procurement and on a predefined interval basis.
c) Training of staff on safe usage of medical equipment upon hiring upon installation of new equipment, and on a predefined regular basis by a qualified person.
d) Inventory of medical equipment, including availability and functionality.
e) Identification of critical medical equipment that should be readily available for the operator even such as life-support equipment, DC shock or AED.
f) Periodic preventive maintenance according to the manufacturer's recommendations which usually recommends using tagging systems by tagging dates and due dates of periodic preventive maintenance or labelling malfunctioned equipment.
g) Calibration of medical equipment according to the manufacturer's recommendations and/or its usage.
h) Malfunction and repair of medical equipment.
i) Dealing with equipment adverse incidents, including actions taken, backup system, and reporting.
j) Updating, retiring and/or replacing medical equipment in a planned and systematic way.
k) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review the PHC medical equipment management plan and related documents, e.g. (inventory of medical equipment, preventive maintenance schedule, calibration schedule, and staff training records).
- During GAHAR survey, surveyor may check medical equipment functionality and trace some medical equipment records.

Evidence of compliance:

1. The PHC has an approved updated medical equipment management plan that addresses all elements from a) through k) in the intent.
2. The PHC has a qualified individual to oversee medical equipment management.
3. The PHC 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.

GSR.19 EFS.11 Essential utilities plan addresses regular inspection, maintenance, testing and repair.

Safety

Keywords:
Utilities Management Plan

Intent:
PHCs are expected to provide safe and reliable healthcare to their patients. Planning appropriate response and recovery activities for a failure of the PHC utility systems is essential to satisfy this expectation.
These systems constitute the operational infrastructure that permits safe patient care to be performed.

Some of the most important utilities include mechanical (e.g., heating, ventilation and cooling); electrical (i.e., normal power and emergency power); domestic hot and cold water as well as other plumbing systems; sewage technology systems, including communications systems and data transfer systems; fire alarm, refrigerators, vertical transportation utilities; fuel systems; access control, and surveillance systems; medical gases, air and vacuum systems. The PHC must have a utility management plan to ensure the efficiency and effectiveness of all utilities that includes at least the following:

a) Inventory of all utility key systems, for example, electricity, water supply, medical gases, heating, ventilation and air conditioning, communication systems, sewage, fuel sources, fire alarms, and elevators.
b) Layout of the utility system.
c) Staff training on utility plan.
d) Regular inspection, testing, and corrective maintenance of utilities.
e) Testing of the electric generator with and without a load on a regular basis.
f) Providing fuel required to operate the generator in case of an emergency.
g) Cleaning and disinfecting water tanks and testing water quality with regular sampling according to laws and regulations.
h) Preventive maintenance plan according to the manufacturer's recommendations.
i) The PHC performs regular, accurate data aggregation, and analysis for example, frequency of failure, and preventive maintenance compliance for proper monitoring, updating, and improvement of the different systems.
j) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review utility management plan to confirm availability of all required systems, regular inspection, maintenance, and backup utilities.
- GAHAR surveyor may review inspection documents, preventive maintenance schedule, contracts, and equipment, as well as testing results of generators, tanks, and/or another key system to ensure of facility coverage 24/7.

Evidence of compliance:

1. PHC has an approved updated plan for utility management that includes items a) through j) in the intent.
2. Staff are trained to oversee utility management.
3. Records are maintained for utility systems inventory, testing, periodic preventive maintenance, and malfunction history.
4. Critical utility systems are identified, and backup availability is ensured.

INFECTION PREVENTION AND CONTROL

GSR.20 IPC.04 Evidence-based hand hygiene guidelines are adopted and implemented throughout the PHC 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 handrub: treatment of hands with an antiseptic handrub 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.
- 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 PHC has a hand hygiene policy that includes at least the following:

a) Hand hygiene techniques
b) Indications for hand hygiene
c) Accessibility of hand hygiene facilities
d) Nail Care and Jewellery
e) Hand hygiene education and training
f) Monitoring and compliance

Survey process guide:

- GAHAR surveyor may review the policy of hand hygiene and hand hygiene guidelines.
- GAHAR surveyor may review hand hygiene educational posters and records.
- GAHAR surveyor may interview PHC staff, enquiring about hand hygiene techniques and WHO five moments of hand hygiene.
- GAHAR surveyor may observe handwashing facilities at each clinic and check the availability of supplies (soap, tissue paper, alcohol hand rub, etc.).
- GAHAR surveyor may observe compliance of healthcare professionals with hand hygiene technique and WHO five moments of hand hygiene.

Evidence of compliance:

1. The PHC has a Hand hygiene policy and procedures based on current guidelines that address all the elements mentioned in the intent from a) through f).
2. Related staff is trained on the policy 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 PHC monitors the reported data on the hand hygiene process and takes actions to control or improve the process as appropriate.

INFORMATION MANAGEMENT AND TECHNOLOGY

GSR.21 IMT.03 The PHC defines standardized symbols and abbreviations.

Efficiency

Keywords:
Use of symbols and abbreviations

Intent:

Symbols and abbreviations are frequently employed to save space by compressing extensive information, but this practice can lead to miscommunication among healthcare professionals and increase the risk of errors in patient care. The PHC shall develop a policy and procedures for approved and non-approved symbols and abbreviations according to the PHC scope of service and approved official language of communication inside the PHC. The policy shall address at least the following:

a) Approved symbols/abbreviations list.

b) Not-to-use symbols/abbreviations list 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) shall not be used, such as in informed consent and any record that patients and families receive from the PHC about the patient's care.

Survey process guide:

- GAHAR surveyor may review PHC policy for abbreviations.
- GAHAR surveyor may review appropriate number of medical records (not less than ten files) to check for the used abbreviations with medication orders.
- GAHAR surveyor may interview medical staff for awareness of the prohibited abbreviations.

Evidence of compliance:

1. The PHC has an approved policy that includes all the points in the intent from a) through d).
2. All staff who record in the patient's medical record are trained on the policy requirements.
3. Symbols and abbreviations, including the approved list, are used according to the policy.
4. Violations of the list of not-to-use symbols/abbreviations are monitored, and corrective actions are taken.

Section 3: Essential Quality Requirements

► Reading and Interpretation of Essential Quality Requirements (EQRs):

Essential quality requirements, the foundation of exceptional healthcare, hinges on a commitment to continuous improvement and a patient-centered approach. The complex interactions between patients, staff, processes, and technology in healthcare demand a strong system to guarantee safe, effective, and fair care. While skilled professionals and established protocols are crucial, the inherent risks within the healthcare system demand a proactive and systematic approach to quality enhancement. The focus on essential quality has evolved significantly, emphasizing the importance of patient involvement, data-driven decision-making, and a culture of continuous learning. Accreditation bodies play a pivotal role in promoting these principles by establishing clear expectations and conducting regular evaluations. Developing robust EQRs is paramount to driving quality improvement across all healthcare settings.

To create effective EQRs, a comprehensive understanding of the critical areas impacting quality is necessary. These include patient rights, access to care, medication safety, infection prevention, workforce management, and information management, among others. These requirements must be grounded in evidence-based practices and aligned with national and international quality standards. As part of the GAHAR accreditation process, PHCs must demonstrate their commitment to essential quality requirements. This necessitates compliance with each of the GAHAR Essential Quality Requirements (EQRs).

Essential Quality Requirements:

Code	Keyword	Standard code
Patient-Centeredness Culture		
EQR.01	Patient and family education process	PCC.04
EQR.02	Waiting spaces	PCC.06
EQR.03	Complaints and suggestion	PCC.10
Access, Continuity, and Transition of Care		
EQR.04	Granting access	ACT.01
EQR.05	Referral process	ACT.09
Integrated Care Delivery		
EQR.06	Cardiopulmonary resuscitation	ICD.13
EQR.07	Immunization program	ICD.14
EQR.08	Pediatric immunization program	ICD.15
EQR.09	Adult immunization program	ICD.16
EQR.10	Child health program	ICD.17
EQR.11	Maternity health program	ICD.18
EQR.12	Reproductive health program	ICD.19
Diagnostic and Ancillary Services		
EQR.13	Medical imaging technical standards	DAS.02
EQR.14	Laboratory technical procedures	DAS.07
Medication Management and Safety		
EQR.15	Life-supporting medications	MMS.05
Infection Prevention and Control		
EQR.16	Standard precaution measures	IPC.05
EQR.17	Disinfection, Sterilization	IPC.07
Organization Governance and Management		
EQR.18	Governing body structure and responsibilities	OGM.01
Workforce Management		
EQR.19	Staffing plan	WFM.01
EQR.20	Staff files	WFM.04

Code	Keyword	Standard code
EQR.21	Orientation program	WFM.05
Information Management and Technology		
EQR.22	Integrity of data and information	IMT.05
EQR.23	Medical record management	IMT.07
EQR.24	Downtime of data systems	IMT.11
Quality and Performance Improvement		
EQR.25	Incident reporting system	QPI.06
EQR.26	Sentinel events	QPI.07

EQR.01 PCC.04 Patient and family education is clearly provided.

Patient-Centeredness

Keywords:

Patient and family education process

Intent:

Patient and family education helps to understand the care process and empower patients and families to make informed decisions. Multiple disciplines, such as physicians, nurses, pharmacists, and medical technicians, not only the assigned health educators or social workers, contribute to the process of educating patients and families during care processes.
The PHC shall develop and implement a policy and procedures to define the process of patient and family education. The policy shall address 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
    ii. Plan of care
    iii. Referral information
b) Multidisciplinary responsibility to educate patients and families
c) Method for education is provided according to patient and family values and level of learning and in a language and format that they understand.
d) The education process is recorded, including patient education needs, health educators, and method used.

Survey process guide:

- GAHAR surveyor may review PHC 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 PHC has a patient and family education policy guiding the process of patient and family education that includes at least the points mentioned in the intent from a) through d).
2. Responsible 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.

EQR.02 PCC.06 Patient-centered waiting spaces are available for various services.

Patient-Centeredness

Keywords:

Waiting spaces

Intent:

Waiting spaces are a major pain point in the patient experience. Patients waiting for medical services often experience heightened emotions like anxiety, fear, confusion, and frustration. These feelings are further intensified by environmental stressors such as uncomfortable seating, insufficient basic amenities, and overcrowded waiting areas. The PHC shall ensure that waiting spaces are comfortable and suitable for patient's and family's needs.

Survey process guide:

- GAHAR surveyor may ensure comfortable spaces and equipment through waiting areas.
- GAHAR surveyor may check toilets and potable water availability through waiting areas.

Evidence of compliance:

1. Waiting spaces are lit, ventilated, clean, and safe.
2. Waiting spaces are planned to accommodate the expected number of patients and family.
3. Waiting spaces provide access to satisfy basic human needs such as toilets and potable water.
4. Patients receive information on how long they may wait.

EQR.03 PCC.10 Patients and families are able to make oral written complaints or suggestions through a defined process.

Patient-Centeredness

Keywords:

Complaints and suggestions

Intent:

While PHCs 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 PHC 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. PHC policy shall address at least the following:

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

Survey process guide:

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

Evidence of compliance:

1. The PHC 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 the complaints policy.
3. The PHC allows the complaining process to be publicly available.
4. Patients and families are allowed to provide suggestions and complaints.
5. Complaints and suggestions are investigated & analyzed by the PHC and resolved in a defined timeframe.
6. Patients and families receive feedback about their complaints or suggestions within approved timeframes and according to the level of urgency of the complaint.

EQR.04 ACT.01 The PHC grants patients access to its services according to applicable laws and regulations and pre-set eligibility criteria.

Patient-Centeredness

Keywords:

Granting access (before patient registration)

Intent:

While WHO member countries embraced the concept of universal health coverage as early as 2005, few have yet achieved the objective. This is mainly due to numerous barriers that hinder access to needed health services. If services are available and there is a continuous supply of services, then the opportunity to obtain healthcare exists, and a population may 'have access' to services. The extent to which a population 'gains access' also depends on social or cultural barriers that limit the utilization of services. Thus, access measured in terms of utilization is dependent on the affordability, physical accessibility, and acceptability of services and not merely the adequacy of supply.

The availability of services and barriers to access, like physical barriers, have to be considered in the context of the differing perspectives, to improve accessibility to the PHC services, patients and families should be informed about the available services and the eligibility criteria to receive these services.

These eligibility criteria are usually pre-set by healthcare payers and guided by laws, regulations, and PHC policies. Pre-set criteria need to be available for those responsible for granting access to patients.

The PHC shall develop and implement a policy and procedures to guide the process of granting access that addresses at least the following:

a) The process of screening patients to determine that the PHC scope of services can meet their healthcare needs.
b) Access through emergency areas should be safe and appropriate for patients' conditions.
c) Access through ambulatory areas includes a clearly defined scheduling and queuing process.
d) Actions to be taken when PHC's scope of service does not match patients' healthcare needs

Survey process guide:

- GAHAR surveyor may review the PHC 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 PHC, 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 PHC has an approved policy for granting access to patients that addresses all elements mentioned in the intent from a) through d).
2. Patients are made aware of the available services, including operating hours, types of services, cost of each service (when relevant), and access path.
3. The PHC defines a system for informing patients and families about services that is suitable for different literacy levels and is available at points of contact and public areas.
4. Patients are referred and/or transferred to other healthcare organizations when the PHC's scope of service does not match their healthcare needs.

EQR.05 ACT.09 Processes of patient referral are defined.

Safety

Keywords:

Referral process

Intent:

For PHCs, an effective patient referral system is an integral way of ensuring that patients receive optimal care at the right time and at the appropriate level, as well as cementing professional relationships throughout the healthcare community.

Recording and responding to referral feedback ensures continuity of care and completes the cycle of referral.

The PHC shall develop and implement a policy and procedures to guarantee the appropriate patient referral within approved timeframe, which is based on identified patient's needs and guided by clinical guidelines/protocols.

The policy shall address at least the following:

a) Planning for referral begins once diagnosis or assessment is settled and, when appropriate, includes the patient and family.
b) Responsible staff member for ordering and executing the referral of patients.
c) Defined criteria determine the appropriateness of referral on the approved scope of service and the patient's needs for continuing care.
d) Coordination with referral agencies, when possible, other levels of health service, and other organizations.
e) The referral sheet shall include at least the following:
    i. Patient identification.
    ii. Reason for referral.
    iii. Collected information through assessments and care.
    iv. Medications and provided treatments.
    v. Transportation means and required monitoring, when applicable.
    vi. Condition on referral.
    vii. Destination on referral.
    viii. Name of the medical staff member who decided the patient referral.

Survey process guide:

- GAHAR surveyor may review a document describing the approved PHC processes for referrals and transfers.
- GAHAR surveyor may visit any clinic to assess staff awareness of the process and may also perform
- GAHAR surveyor may also interview healthcare professionals to check their awareness of the process.

- GAHAR surveyor may review a closed file for patient's medical record of patient who were transferred or referred.

Evidence of compliance:

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

EQR.06 ICD.13 Response to cardio-pulmonary arrest in the PHC is managed for both adult and pediatric patients.

Safety

Keywords:

Cardiopulmonary resuscitation

Intent:

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

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

Survey process guide:

- GAHAR surveyor may review the PHC policy guiding the safe management of cardio-pulmonary arrests
- GAHAR surveyor may interview involved staff members to ensure their awareness of the PHC 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 PHC.

Evidence of compliance:

1. The PHC has an approved policy that addresses all the elements mentioned in the intent from a) through h).
2. Responsible staff members are aware of the PHC policy.
3. Trained individuals are responsible for the management of cardio-pulmonary arrests with evidence of training on basic life support.
4. Age-appropriate emergency equipment, medications, and supplies are available throughout the PHC.
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

EQR.07 ICD.14 The immunization program is performed according to laws, regulations, and guidelines.

Effectiveness

Keywords:
Immunization program

Intent:
To ensure client safety and prevent errors, the PHC has to follow a predetermined vaccination procedure.
This standard is applicable only when the PHC scope of services includes a vaccination program, which is prepared on the base of the Expanded Program of Immunization (EPI) guidelines. The PHC has to follow up on the immunization defaulters/dropouts in order to complete the required vaccinations and determine the root causes to eliminate them in the future. The vaccination room shall follow MOHP regulations; location, structure, and equipment are suitable for services provided to children and clients. Vaccination procedures are appropriately done according to EPI guidelines, including checking the timetable, correct dose, appropriate route, and child position.

Survey process guide:

- When applicable according to the scope of PHC, GAHAR surveyor may review the PHC Immunization program and instructions guiding the follow-up of immunization defaulters.
- GAHAR surveyor may interview staff members to check their awareness of the policy.
- GAHAR surveyor may observe vaccination room location, doors, presence of hand hygiene facilities, necessary equipment and supplies.
- GAHAR surveyor may review the rate of immunization defaulters.

Evidence of compliance:

1. The vaccination room is easily accessible, separate room of suitable area with separate entrance and exit doors.
2. There are hand hygiene facilities, cooling box, ice packs, refrigerator, thermometer, and refrigerator temperature monitoring sheet.
3. Responsible staff members are trained on vaccination procedures.
4. Coverage percentage of each vaccination in the national immunization schedule is periodically calculated and recorded including the rate of immunization defaulters.
5. There is a written instruction on how to follow up on immunization defaulters.

EQR.08 ICD.15 The pediatric immunization program is performed according to laws, regulations, and guidelines.

Safety

Keywords:

Pediatric immunization program

Intent:

Immunization services should be designed to meet the needs of patients. Relying only on appointment-based systems can create barriers to access in both public and private healthcare settings. To ensure accessibility, immunization services should be available on a walk-in basis at all times for both routine patients and those newly registered. Children coming only for vaccinations should be rapidly and efficiently screened without requiring other comprehensive health services. If the PHC isn't providing this service, it is mandatory to ensure that the community in the catchment area receives it, even if other organizations are providing it. The PHC needs to demonstrate efforts to ensure that community needs are responded to. The PHC shall develop and implement a policy and procedures to guide the pediatric immunization program. The policy shall address at least the following:

a) A pre-vaccination assessment may include observing the child's general state of health, asking the parent if the child is well, and questioning the parent about potential contraindications.

b) Each encounter with a healthcare professional, including an emergency room visit, is an opportunity to screen vaccination status and, if indicated, administer needed vaccines.

c) Professionals should educate parents in a culturally sensitive way about the importance of immunizations, the diseases they prevent, the recommended vaccination schedules, the need to receive vaccinations at recommended ages, and the importance of bringing their child's immunization record to each visit.

d) Minimally acceptable screening procedures for precautions and contraindications include asking questions to elicit a possible history of adverse events following prior immunizations and determining any existing precautions or contraindications.

e) Accepting conditions that are not true contraindications often results in the needless deferment of indicated immunizations.

f) The simultaneous administration of childhood vaccinations is safe and effective.

g) Providers use accurate and complete recording procedures.

h) Providers of immunization-only services that require an appointment should co-schedule immunization appointments with other needed health-care services such as well baby clinic visits, dental examinations, or developmental screening, provided such scheduling does not create a barrier by delaying needed immunizations.

i) Providers should encourage parents to inform them of adverse events following immunization.

Survey process guide:

- When applicable according to PHC scope of services, GAHAR surveyor may review policy and procedures guiding the pediatric immunization program.
- GAHAR surveyor may review reported adverse events following vaccination.
- GAHAR surveyor may observe pediatric vaccination records.
- GAHAR surveyor may interview parents to assess their experience and education they received about pediatric immunization.

Evidence of compliance:

1. The PHC has an approved policy and procedures to guide the process of paediatric immunization as addressed in the intent from point a) through i).
2. Healthcare providers utilize all clinical encounters to screen and, when indicated, vaccinate children.
3. Healthcare providers educate parents about immunization in general terms and question parents about contraindications and, before vaccinating a child, inform them in specific terms about the risks, benefits and potential adverse events of the vaccinations their child is to receive.
4. Healthcare professionals administer simultaneously all vaccine doses for which a child is eligible at the time of each visit, except when contraindicated.
5. Healthcare professionals report adverse events following vaccination promptly, accurately, and completely.

EQR.09 ICD.16 The adult immunization program is performed according to laws, regulations, and guidelines.

Effectiveness

Keywords:
Adult immunization program

Intent:

Globally, adult vaccination rates are extremely low, and research shows that there are many missed opportunities for vaccination of adult patients during clinical encounters. A global trend of recommending and offering vaccines at the same visit is initiated. Usually, patients need empowerment by being informed about vaccinations by providing them with up-to-date information about the benefits and potential risks of each vaccine they need. Healthcare providers need to share the tailored reasons why the recommended vaccine is right for the patient, given his or her age, health status, lifestyle, occupation, or other risk factors. Healthcare providers may highlight positive experiences with vaccines, as appropriate, to reinforce the benefits and strengthen confidence in vaccination and address patient questions and any concerns about the vaccine, including side effects, safety, and vaccine effectiveness, in plain and understandable language. Healthcare providers may remind patients that vaccines protect them and their loved ones from many common and serious diseases and explain the potential costs of getting the disease, including serious health effects, time lost (such as missing work or family obligations), and financial costs. PHC staff should be trained and educated on vaccine storage, handling, and administration, and they ensure proper care for patients. The PHC needs to identify those patient groups that would highly need to be vaccinated, such as pregnant women, living in endemic areas for communicable diseases, travelers to endemic areas, pilgrims, contacts of certain communicable diseases, targeted populations by national campaigns, and others. Then, actions are taken to provide sufficient education and support. If the PHC isn't providing this service, it is mandatory to ensure that the community in the catchment area receives it, even if other organizations are providing it. The PHC needs to demonstrate efforts to ensure that community needs are responded to.

Survey process guide:

- When applicable according to PHC scope of services, GAHAR surveyor may review policy and procedures guiding the adult immunization program.
- GAHAR surveyor may review vaccination protocols at all locations where vaccines are administered.
- GAHAR surveyor may observe adult vaccination records and pregnant vaccination records.
- GAHAR surveyor may interview patients to assess their experience and the education they received about the adult immunization program.

Evidence of compliance:

1. The PHC has an approved policy to ensure safe and effective adult immunization.
2. Healthcare professionals are aware of the approved policy.
3. Written vaccination protocols are available at all locations where vaccines are administered.
4. Patients are educated about the risks and benefits of vaccination in easy-to-understand language.
5. Vaccination records for patients are accurate and easily accessible.
6. Pregnant women are provided with necessary immunization in accordance with MOHP and WHO recommendations and clinical guidelines.

EQR.10 ICD.17 The child health program is effective and covers all newborns, infants, preschool, and school-age children, according to national guidelines.

Effectiveness

Keywords:
Child health program

Intent:
Childhood is the most critical period of life associated with morbidity and mortality. Optimum health is a basic child right. Focusing on child health promotion is important to achieve sustainable development goals. Physicians play an important role in the identification of neonatal health problems (congenital abnormalities, hypothyroidism, conjunctivitis) and followup. Furthermore, the proper assessment and care of children play an important role in the prevention of unnecessary consultation, reduced hospitalization, and inappropriate referral. Every child needs to be assessed regularly for growth and development to ensure they are within the normal limits.
Regular assessment fosters early detection and management of any deviation from normal growth, good nutrition, and good health. Assessment may include the identification of risk factors that could be familial, maternal, or child-related. The PHC has an important role in the identification and referral of children with high-risk factors and poor social determinants of health to appropriate services and authorities. The PHC should act on meeting the child's educational, preventive, and curative needs, address the social determinants of health, and empower families to improve their child's health. If the PHC isn't providing this service, it is mandatory to ensure that the community in the catchment area receives it, even if other organizations are providing it. The PHC needs to demonstrate efforts to ensure that community needs are responded to. The PHC shall develop a child health program that includes at least the following:

a) Registration.
b) Identification of newborn health issues.
c) Periodic examination, including growth and development assessment.
d) Health education.
e) Nutrition care.
f) Management of childhood illnesses or referrals according to condition.
g) Follow-up.
h) Identification, management, or referral of high-risk children according to condition.

Survey process guide:

- GAHAR surveyor may review the child health program inside the PHC.
- GAHAR surveyor may review medical records to check that child growth charts and results are recorded.
- GAHAR surveyor may review a sample of children medical records to evaluate compliance with growth and development assessment, immunization status recording.

Evidence of compliance:

1. The PHC has a child health program that covers all components mentioned in the intent from a) through h).

2. All physicians and nurses are trained on child health programs and clinical guidelines.
3. Every child is checked for growth and development using growth charts, and results are recorded in the child's medical record.
4. Every child is screened for development using an assessment chart with development milestones (motor, language, cognitive, social, and psychological), and results are recorded in the child's medical record.
5. Any child less than five years old is checked for his immunization status, and results are recorded in the patient's medical record.
6. High-risk children are identified and managed according to the PHC's program and clinical guidelines.

EQR.11 ICD.18 The maternal health program is performed according to laws, regulations, and national guidelines.

Effectiveness

Keywords:
Maternity health program

Intent:
According to PHC's scope of service, maternity may include parental counselling, antenatal care, management of high-risk pregnancies, management of normal labour, and postnatal care. Parents may be assessed for the probability of having babies with inheritable diseases. Counseling helps parents to understand the condition, and expected risk and prepares them for the birth of a child with special needs. Health education is an important component of antenatal care as it enables women to make better-informed decisions about health issues during their pregnancies, thus ensuring a safe outcome. Antenatal care is a critical opportunity for healthcare providers to perform proper assessments, provide care, information, and support to pregnant women in order to have a safe delivery and to give birth to a full-term and healthy baby. Repeated antenatal care visits ensure a safe pregnancy and early detection of problems, and offer support and assurance to pregnant women and families. A number of diagnostic tests are recommended for pregnant women for the identification of risks for the mother and the fetus. Early detection of risk factors during pregnancy is important for the mother's and baby's safety and for better pregnancy outcomes. The risk factor may be detected at the first visit or during recurrent antenatal visits. The PHC should have a policy that addresses at least the following:

a) A comprehensive package of maternal health services to promote the health of the mother, prevention and early detection of complications, and emotional and psychological support.
b) Tracking of pregnancy using pregnancy cards, including a table of antenatal care visits timing, required examination, investigations, immunization, education, and counseling.
c) Proper assessment of pregnant women, including full history, risk factors screening, psychological and nutritional assessment, clinical examination, laboratory investigations, and ultrasound when indicated.
d) Standard antenatal care is given, including regular visits, Immunization, and health education on nutrition, risk symptoms, signs, and medication use during pregnancy.
e) Care for high-risk cases.
f) Contacting and following up with dropouts from the program.

Survey process guide:

- GAHAR surveyor may review the PHC policy guiding maternity health.
- GAHAR surveyor may interview responsible staff to check their awareness of policy and risk factors detection.
- GAHAR surveyor may review a sample of pregnant medical records to evaluate compliance with high-risk pregnancy management/ or referral.
- GAHAR surveyor may review antenatal and postnatal visits tracking and records.

Evidence of compliance:

1. The PHC maternity health program policy and procedure to ensure safe and effective maternal health care that covers items mentioned from a) through f).
2. All staff are trained in maternal health programs and risk factors detection.
3. Recurrent antenatal visits schedule and care are performed, tracked, and recorded.
4. High-risk pregnancies are managed or referred according to clinical guidelines.
5. Postpartum care is given to both mother and newborn, and recorded.
6. The PHC monitors the reported data of antenatal and postnatal visits and takes actions to control or improve the process, as appropriate.

EQR.12 ICD.19 The reproductive health program is performed according to laws, regulations, and guidelines.

Effectiveness

Keywords:
Reproductive health program

Intent:
Reproductive health education and counseling aim to provide appropriate information to clients to identify and assess their own needs and help them to make their own informed decisions. It is a two-way interaction between a healthcare provider and married couples to assess and address the couples' overall needs, knowledge, and concerns. The PHC shall develop a policy that addresses at least the following:

a) Counseling in reproductive health and family planning.
b) Premarital examination, as applicable.
c) Family planning.
d) Reproductive tract infections (RTI) and sexually transmitted diseases (STD).
e) Infertility.
f) Insertion and removal of family planning devices.

Survey process guide:

- GAHAR surveyor may review the PHC policy guiding reproductive health.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with reproductive health and family planning policy.
- GAHAR surveyor may interview responsible staff to check their awareness of the policy.
- GAHAR surveyor may interview patients or family members to assess their experience.
- GAHAR surveyor may observe the area for reproductive health and family planning counseling and ask about education materials, and tools availability.

Evidence of compliance:

1. The PHC has an approved policy and procedure for reproductive health and family planning that covers all elements mentioned in the intent from a) through f).
2. Responsible staff are trained on reproductive health and family planning services as per the scope of services.
3. Available reproductive health services are performed according to approved policies.
4. Reproductive Health education needed messages, material, and tools are available.
5. There is a special place for reproductive health and family planning counselling and education.

EQR.13 DAS.02 Performance of medical imaging studies is standardized.

Effectiveness

Keywords:

Technical standards (practice parameters)

Intent:

Medical imaging service encompasses different techniques, modalities, processes to analyze 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 prepared procedure manual provides a foundation for the medical imaging services 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 problems and measure acceptable performance when evaluating staff.

The medical imaging service shall develop technical procedures for all study types. The technical medical imaging 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 PHC shall develop and implement procedures for medical imaging to ensure the safety and usability of modalities. For each modality, procedure manuals shall address at least the following:

a) Scope and general overview.
b) Pre-examination, examination, and post-examination procedures.
c) Equipment description.
d) Maintenance procedures.
e) Quality control.
f) Safety procedures.

Survey process guide:

- GAHAR surveyors may review a sample of medical imaging procedure manuals and check for their availability.
- GAHAR surveyors may interview staff to check their awareness of the procedure manual.
- GAHAR surveyor may visit areas where medical imaging 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 for the medical imaging staff members.
3. Each procedure includes all the required elements from a) through f) in the intent
4. Staff are trained and knowledgeable of the contents of procedure manuals
5. The procedures are consistently followed

EQR.14 DAS.07 Performance of laboratory technical procedures is standardized.

Effectiveness

Keywords:

Technical Procedures

Intent:

Laboratory service encompasses different techniques and 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 prepared procedure manual provides a foundation for the laboratory's quality assurance program. Its purpose is to ensure consistency while striving for quality. The procedure manual may be used to document how tests are performed, Train new staff members, remind staff members of how to perform infrequently ordered tests,

troubleshoot testing problems and measure acceptable test performance when evaluating staff. The laboratory shall develop technical procedures for all test methods. The technical laboratory procedures should be written in a language commonly understood by the working staff and available in an appropriate location. It could be in a paper-based, electronic, or web-based format.
The Laboratory technical procedures are consistently followed and regularly reviewed. They include at least the following:

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

Survey process guide:

- GAHAR surveyor may review laboratory procedures.
- GAHAR surveyor may trace and observe a patient undergoing a laboratory service and review preparation processes.
- GAHAR surveyor may interview laboratory staff members to check their awareness of analytic procedures.
- GAHAR surveyor may visit areas laboratory service areas to observe medical calibration, reagent use, ranges, and results.
- GAHAR surveyor may review quality control procedures and records, documented regular review of the quality control data, and the action taken for outliers or trends.

Evidence of compliance:

1. The laboratory has a written procedure available to relevant staff for each analytical test method that addresses all elements mentioned in the intent from a) through e).
2. Laboratory staff are trained and updated about the technical laboratory procedure.
3. Appropriate pre-examination processes are implemented, including complete requesting forms, proper patient identification, proper sampling techniques, proper sample labeling and proper sample transportation.
4. Appropriate examination processes are implemented, including documentation of examination procedures and identification of biological reference intervals.
5. Appropriate post examination processes are implemented including the process of sample storage, defined retention time of laboratory results, and release of reports to the authorized recipients.
6. Internal and external quality control measures are performed and periodically reviewed, and appropriate corrective action is taken.

EQR.15 MMS.05 Life-supporting medications are available, accessible, and secured at all times.

Safety

Keywords
Life supporting medications

Intent

In situations when a patient emergency occurs, quick access to life supporting medications is critical and may be lifesaving. Life supporting medications shall be readily accessible and uniformly stored to facilitate quick access to the right medication to meet emergency needs.
The PHC develops and implements policy and procedures to ensure the availability of life-supporting medications that address at least the following:

a) The availability, accessibility, and distribution of life-supporting medications to facilitate quick access to the right medication and to meet emergency needs for all categories of patients including pediatrics.
b) Prevention of abuse, loss, or theft of life-supporting medications to ensure their availability when needed.
c) Replacement of life-supporting medication at the most appropriate time when used, damaged, or outdated.

Survey process guide

- GAHAR surveyor may review the PHC policy for lifesaving medication management.
- GAHAR Surveyor may observe lifesaving medications storage areas.
- GAHAR surveyor may interview staff members who are responsible for lifesaving medications storage to inquire about storage conditions, accessibility, storage security and replacement of medications when needed.

Evidence of compliance

1. The PHC has an approved policy to guide life supporting medications availability that addresses at least all elements mentioned in the intent from a) through c).
2. Life-supporting medications are appropriately available and accessible when required.
3. Life-supporting medications are uniformly stored in all locations.
4. Life-supporting medications are replaced within a predefined timeframe when used, damaged, or outdated.

EQR.16 IPC.05 Standard precautions measures are implemented.

Safety

Keywords:
Standard precaution measures

Intent:
According to CDC, standard precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. In addition to hand hygiene, standard precautions include:

I. Use of personal protective equipment (PPE) (e.g., gloves, masks, eyewear).
II. Use of soap, washing detergents, antiseptics, and disinfectants.
III. Respiratory hygiene / cough etiquette.
IV. Sharps safety (engineering and work practice controls).
V. Safe injection practices (i.e., an aseptic technique for parenteral medications).
VI. Sterile instruments and devices.
VII. Clean and disinfect environmental surfaces.

Proper selection of standard precautions depends on risk assessments that are performed at the points of care, so staff education and training are, therefore, of utmost importance.
Respiratory hygiene interventions should focus on patients and accompanying individuals exhibiting respiratory symptoms. Healthcare professionals shall always use a sterile, single-use disposable syringe or needle for each injection given, and ensure that all injection equipment and vials remain free from contamination.
Training shall be performed in the proper way and sequence of donning and doffing of various personal protective equipment to maintain maximum protection throughout the process. PHC shall have a clear method and schedule for environmental cleaning and disinfection including walls, floors, ceilings, and furniture; this shall be performed according to the classification of areas.

The schedule shall address environmental cleaning activities for each area as follows:

a) Activities to be done every day.
b) Activities to be done every shift.
c) Deep cleaning activities.

Survey process guide:

- GAHAR surveyor may observe the availability, accessibility, and use of detergents, antiseptics, and disinfectants in the relevant areas.
- GAHAR surveyor may observe the availability and accessibility of PPE and may interview staff members to inquire about the constant availability, accessibility, and proper use of PPE.
- GAHAR surveyor may observe the availability of respiratory hygiene /cough etiquette posters in appropriate places.

Evidence of compliance:

1. The PHC provides PPE, detergents, antiseptics, and disinfectants that are readily available, easily accessible, with standardized product specifications needed for the task.
2. Respiratory hygiene/cough etiquette posters are displayed at appropriate places.
3. Intravenous bottles are not used interchangeably between patients, usage of multi-dose vials is performed as per approved procedures and usage of single dose vials is done whenever possible.
4. Cleaning activities and times are listed for each area and include all elements mentioned in the intent from a) through c).
5. All medical procedures are performed in an environment that does not pose a risk of infection.
6. Related staff receive training on the standard precaution measures.

EQR.17 IPC.07 Patient care equipment is disinfected/sterilized based on evidence-based guidelines and manufacturer recommendations.

Safety

Keywords:

Disinfection, sterilization

Intent:

Processing of patient care equipment is a very critical process inside any PHC. In clinical procedures that involve contact with medical/surgical equipment, it is crucial that healthcare professionals follow standard practices and guidelines to clean, 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 processing area. The assigned processing area shall have workflow direction. The PHC shall develop and implement a policy and procedures to guide the process of sterilization/disinfection. The policy shall address at least the following:

a) Receiving and cleaning of used items.
b) Preparation and processing.
   i. Processing method to be chosen according to 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. Chemical disinfectants approved for high-level disinfection include glutaraldehyde, orthophtaldehyde, and hydrogen peroxide.
   ii. Sterilization shall be used for all critical and heat-stable semi-critical items.
   iii. Low-level disinfection (for only non-critical items) shall be 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) Labeling 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 shall 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 observe 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 observe the ability of the staff to perform the sterilization process properly.

Evidence of compliance:

1. The PHC has an approved policy to guide the process of disinfection and sterilization that addresses all element in the intent from a) through g).
2. Responsible staff is trained on approved policy.
3. The PHC has at least one functioning pre-vacuum class B sterilizer.
4. Laws and regulations, Spaulding classification, and manufacturer's requirements and recommendations guide sterilization or disinfection.
5. There is a physical separation between the contaminated and clean areas.
6. Clean and sterile supplies are properly stored in designated storage areas that are clean and dry and protected from dust, moisture, and temperature extremes.

EQR.18 OGM.01 The PHC 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 PHC's direction and ensuring the alignment of its activity with its purpose. Such a body is also responsible for monitoring its performance and future development. Therefore, defining the governing structure of a PHC ensures that it operates effectively and efficiently. In a centralized system, one governing body governs several subsidiary organizations. Governing bodies are responsible for the health and wealth of their organization and are thus accountable primarily for its sustainability. Therefore, to establish an accountability statement, governing bodies have to first identify their principal stakeholders and then define in what way they are accountable to them. The governing body is also responsible for developing the mission statement. A clear two-way communication process between governance and management, usually between the head of the governing body and the PHC director, enhances the PHC's well-being. Governing body responsibilities shall be defined and directed towards the PHC's principal stakeholders and shall include:

a) Defining the PHC's mission, vision and values.
b) Support, promotion, and monitoring of performance improvement, patient safety, risk management efforts, and safety culture.
c) Setting priorities for activities to be executed by the PHC; The process of prioritization among selected activities follows this process of selection.
d) Prioritization criteria should be known to all to ensure a fair and transparent resource allocation process.
e) Reviewing the clinical governance activities and receives regular reports.
f) Approval of:

I. The PHC's strategic plan.
II. The operational plan and budget, capital investments.
III. The quality improvement, patient safety, and risk management programs.
IV. Community assessment and involvement program.

PHCs need to define the types of communication channels between the governing body, the management team, and the PHC 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 the governing body's role and responsibilities through the whole process of the survey, with special attention given to the opening presentation, document review session, and leadership interview session; questions shall include reviewing the required documents and checking their details and approvals in addition to reviewing monitoring reports of the approved plans.
- GAHAR surveyor may observe the mission statement posters, brochures, or documents focusing on its last update, approval, alignment and visibility.
- GAHAR surveyor may observe evidences of open defined communication channels, frequency of communication and evidence of feedback to submitted reports on both sides.

Evidence of compliance:

1. The governing body structure is represented in the PHC chart.
2. The governing body meets at predefined intervals, and minutes of meetings are recorded.
3. The PHC has vision and mission statements approved by the governing body and are visible in public areas to staff, patients, and visitors.
4. The governing body has defined its responsibilities and accountabilities towards the PHC's principal stakeholders as mentioned in the intent from a) to f) and has a process for resource allocation that includes clear criteria for selection and prioritization.
5. The strategic plan, operational plans, budget, quality improvement, and risk management programs are approved, monitored, and updated by the governing body.
6. The governing body members and PHC leaders are aware of the process of communication and approve the communication channels.

EQR.19 WFM.01 The PHC staffing plan matches the PHC's mission and professional practice recommendations.

Efficiency

Keywords:
Staffing plan

Intent:

Staff planning is the process of making sure that a PHC has the right people to carry out the work needed for business successfully through matching up detailed staff data including number of staff, skills, potential, aspirations and location with business plans. The staffing plan sets the number of staff and defines the desired skill mix, education, knowledge, and other requirements of staff members**.**
The shortage of competent healthcare professionals in multiple areas is an alarming sign. The PHC shall comply with laws, regulations and recommendations of professional practices that define desired education levels, skills, or other requirements of individual staff members or that define staffing numbers or mix of staff for the PHC. The plan is reviewed on a regular basis and updated as necessary. The leaders of each clinical or managerial area define the individual requirements of each staff position. The PHC should

maintain a safe level of staff members' numbers and skill levels. Leaders consider the following factors to project staffing needs:

a) The PHC mission, strategic and operational plans.
b) Complexity and severity mix of patients served by the PHC.
c) Services provided by the PHC.
d) Technology and equipment used in patient care.
e) Workload during working hours and different shifts.

Survey process guide:

- GAHAR surveyor may review the staffing plan.
- GAHAR surveyor may review staff files to check compliance of staffing plan to laws, regulations and professional practices recommendations.

Evidence of compliance:

1. The staffing plan matches the mission, strategic, and operational plans.
2. The staffing plan complies with laws, regulations, and recommendations of professional practice.
3. The staffing plan identifies the estimated needed staff numbers including independent practitioner, skills and to meet the PHC needs.
4. The staffing plan is monitored and reviewed at least annually.

EQR.20 WFM.04 The PHC has a staff file for each workforce member.

Efficiency

Keywords:
Staff files

Intent:

It is important for the PHC to maintain a staff file for each staff member. An accurate staff file provides recording of staff 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 staff member in the PHC, including independent practitioners, shall have a record(s) with information about his/ her qualifications, required health information, such as immunizations and evidence of immunity, evidence of participation in orientation as well as ongoing in-service and continuing education; results of evaluations, including staff member performance of job responsibilities and competencies, and work history. The records shall be standardized and kept current according to the PHC policy. Staff files may contain sensitive information and thus should be kept confidential. The PHC should develop a policy and procedures that guide the management of staff files. The policy shall 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 and experience.
    iii. Documentation of credentials evaluation and primary source verification.
    iv. Current job description.
    v. Evidence of initial evaluation of the staff member's ability to perform the assigned job.
    vi. Recorded evidence of newly hired general, departmental, and job-specific orientation.
    vii. Ongoing in-service and professional education received.
    viii. Copies of within-three-months evaluations and copies of annual evaluations.
c) Update of file contents.
d) Storage.

e) Retention time.
f) Disposal.

Survey process guide:

- GAHAR surveyor may review the PHC policy guiding staff file management.
- GAHAR surveyor may interview the staff involved in creating, using, and storing staff files to assess their awareness.
- GAHAR surveyor may review a sample of staff files to assess the standardized contents.
- GAHAR surveyor may observe the area where staff files are kept and assess storage conditions, retention, confidentiality and disposal mechanism.

Evidence of compliance:

1. The PHC has an approved policy that addresses at least elements from a) through f) in the intent.
2. Staff members who are involved in creation, storage, and use of staff files are aware of the management of staff files policy.
3. Staff files are confidential and protected.
4. Staff files include all the required records, including from i) through viii), as mentioned in the intent.
5. Staff files are disposed of as per the management of staff files policy.

EQR.21 WFM.05 All PHC staff undergo a formal orientation program.

Effectiveness

Keywords:
Orientation program

Intent:

A new staff members need to understand the entire PHC structure and how their specific clinical or non-clinical responsibilities contribute to the PHC mission. This is accomplished through a general orientation to the PHC and their role and a specific orientation to the job responsibilities of their position. Staff orientation, especially when first employed, with the PHC policies, shall ensure alignment between PHC mission and staff activities. It also helps to create a healthy PHC 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 rapidly form effective teams that offer safe and quality care. The PHC shall build a comprehensive orientation program that is provided to all staff members regardless of their terms of employment. Staff orientation shall occur on three levels: General orientation, service/unit orientation, and job-specific orientation.
The general orientation program shall address at least the following:

a) Review of the PHC mission, vision and values.
b) PHC structure.
c) PHC policies for the environment of care, infection control, and performance improvement.
d) Patient safety and risk management.
e) Ethical framework and code of conduct.

The Service/Unit orientation program shall address at least the following:

f) Review of relevant policies and procedures.
g) Operational processes.
h) Work relations.

Job Specific orientation shall address at least:

i) Job-specific duties and responsibilities as per the job description.
j) High-risk processes.
k) Technology and equipment use.

l) Staff safety and health.

The PHC shall develop a staff manual that describe processes of staff appointment and reappointment, staff appraisal, staff complaints management, staff satisfaction measurement, code of ethics, disciplinary actions, and termination.

Survey process guide:

- GAHAR surveyor may interview some staff members and inquire about the process of orientation.
- GAHAR surveyor may review a sample of staff files to check evidence of attendance of general, service/unit, and job specific orientation.

Evidence of compliance:

1. The general orientation program is performed, and it includes at least the elements from a) through e) in the intent.
2. Service/unit orientation program is performed, and it includes at least the elements from f) through h) in the intent.
3. Job specific orientation program is performed, and it includes at least the elements from i) through l) in the intent.
4. All new staff members, including contracted and outsourced staff, attend the orientation program regardless of employment terms.
5. Orientation program completion is recorded in the staff file.

EQR.22 IMT.05 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 to the design, implementation, and usage of any information system which stores, processes, or retrieves data as it reflects the maintenance and the assurance of the 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 record and information shall be 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 updated and decrease the likelihood and impact of electronic health information being accessed, used, disclosed, disrupted, modified, or destroyed in an unauthorized manner. The medical records storage area shall implement measures to ensure medical records protection, e.g., controlled access and the suitable type 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 patient's medical records protection measures that include suitable type of fire extinguishers in archiving, storage area and in computers areas.

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, including clinics and the medical records archiving unit.
3. Medical records storage areas implement measures to ensure medical information integrity.

4. When an integrity issue is identified, actions are taken to maintain integrity.

EQR.23 IMT.07 The patient's medical record is managed to ensure effective patient care.

Effectiveness

Keywords:

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.
Without a unified structure of the patient's medical record, each healthcare professional will have their own solution, and the result will be the incompatibility of systems and the inability to share information. Every patient evaluated or treated in the PHC must have a medical record. The file is assigned a unique number to the patient or family, which is used to link the patient with his or her health record. A single file with a unique number enables the PHC to locate a patient's medical record easily and document the care of the patient over time. The patient's medical record shall 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 patient's medical record shall be available to assist the healthcare professional in having quick access to patient information and also to promote continuity of care and patient satisfaction. The PHC shall develop a policy and procedures for medical record management. The policy shall address 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 policy for medical record management.
- GAHAR surveyor may check that each patient's/family's medical record has a unique identifier for each patient, medical record contents, format, and location of entries as well as 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 patient's medical records in the PHC.

Evidence of compliance:

1. The PHC has an approved policy that includes all the points in the intent from a) through e).
2. All staff who are using patient's medical record 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 patients' medical records are available when needed by a healthcare professional and contain up-to-date information within an appropriate time frame.
6. There is a medical record tracking system that facilitates the identification of medical records current location.

EQR.24 IMT.11 Response to planned and unplanned downtime of data systems is tested and evaluated.

Efficiency

Keywords:

Downtime of data systems

Intent:

Downtime event is any event where a Health information technology system (computer 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 the care delivery and interruption of the operations, in addition to the risk of data loss. The PHC 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. All staff shall receive training about the transition into a downtime environment in order to respond to immediate patient care needs.

Survey process guide:

- GAHAR surveyor may review documents of the planned and unplanned downtime program, followed by checking the implementation of the process by review of the related documents, which include workflow and work instructions for planned and unplanned downtime, stock of needed forms to be used during downtime and result of annual program testing.
- GAHAR surveyor may interview staff to assess their awareness of 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 PHC tests the program at least annually to ensure its effectiveness.

EQR.25 QPI.06 An incident-reporting system is developed.

Safety

Keywords:

Incident reporting system

Intent:

Strong risk management is supported by efficient incident reporting systems that, as defined by the system, can identify an incident that could be any event that affects patient or employee safety. Reporting incidents has an important influence on improving patient safety. They can provide valuable insights into how and why patients can be harmed at the PHC level. In most PHCs, injuries, patient complaints, medication errors, equipment failure, adverse reactions to drugs or treatments, or errors in patient care shall be included and reported. Incident reports policy helps to detect, monitor, assess, mitigate, and prevent risks that includes at least the following:

a) List of reportable incidents, near misses, adverse events and sentinel events.
b) Incident management process includes how, when, and by whom incidents are reported and investigated.
c) Incidents requiring immediate notification to the management.
d) Incident classification, analysis, and results reporting.
e) Indication for performing intensive analysis and its process.

Adverse events can have significant negative consequences for both patients and staff. The PHC should understand the emotional and psychological impact of such incidents and should be dedicated to offering comprehensive support to the affected patients and staff, including both immediate and ongoing assistance. Transparent communication and thorough follow-up are ensured to address any concerns, fostering a culture of safety and trust.

Survey process guide:

- GAHAR surveyor may review the incident reporting policy, incident reporting list, a sample of reported incidents, and assess the corrective actions taken.
- GAHAR surveyor may interview staff to check their awareness of the incident-reporting system including identification, analysis, and correction of gaps to prevent future re-occurrence.

Evidence of compliance:

1. The PHC has an approved incident-reporting policy that includes items from a) through e) in the intent.
2. All staff are aware of the incident-reporting system, including contracted and outsourced services.
3. Reported incidents are investigated, and corrective actions are taken within the defined timeframe.
4. The PHC communicates with patient's/services users on any related adverse events they are affected by and provides both immediate and ongoing assistance.
5. The PHC provides emotional, psychological, and professional support to staff affected by adverse events.

EQR.26 QPI.07 The PHC defines, investigates, analyzes and reports sentinel events and takes corrective actions to prevent harm and recurrence.

Safety

Keywords:
Sentinel events

Intent:
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury. Serious injury specifically includes loss of limb or function. A sentinel event signals an immediate investigation and response. The PHC is required to develop a policy for sentinel event management that includes at least the following:

a) Definition of sentinel events such as:
   i. Unexpected mortality or major permanent loss of function not related to the natural course of the patient's illness or underlying condition.
   ii. Wrong patient, wrong site, wrong procedure events.
   iii. Patient suicide or attempted suicide leading to death or permanent loss of function.
   iv. Any post-partum maternal death.
   v. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.
b) Internal reporting of sentinel events.
c) External reporting of sentinel events.
d) Team member's involvement.
e) Root cause analysis.
f) Corrective action plan taken.

All sentinel events are communicated to GAHAR within 48 hours of the event or becoming aware of the event. All events that meet the definition shall have a root cause analysis in order to have a clear understanding of contributing factors behind the system gaps. The analysis and action shall be completed within 45 days of the event or becoming aware of the event.

Survey process guide:

- GAHAR surveyor may review the PHC policy for the management of sentinel events.
- GAHAR surveyor may review a sample of reported sentinel events and assess the investigation, root cause analysis, and corrective actions that were taken.
- GAHAR surveyor may interview PHC leaders to check their awareness.

Evidence of compliance:

1. The PHC has a sentinel events management policy covering the intent from a) through f), and leaders are aware of the policy requirements.
2. All sentinel events are analyzed and communicated by a root cause analysis in a time period specified by leadership that does not exceed 45 days from the date of the event or when made aware of the event.
3. All sentinel events are communicated to GAHAR within 48 hours of the event or becoming aware of the event.
4. The root cause analysis identifies the main reason(s) behind the event and the leaders take corrective action plans to prevent recurrence in the future.

Section 4: Operating Manual

► Reading and Interpretation of the Operating Manual

The operating manual outlines all the documents required in GAHAR Handbook of Primary Healthcare Accreditation Standards (policies, procedures, plans, programs, lists, etc.).
All of these documents should be available for the purpose of reviewing by GAHAR's surveyors during the Provisional Accreditation survey.
The survey process regarding the operating manual section will be conducted through interviews with the PHC leaders regarding their related documents and how they developed them including their plans for implementation.
The required list of documents is categorized according to GAHAR Handbook of Primary Healthcare Accreditation Standards chapters as follow:

- Patient centeredness culture
- Access, continuity, and transition of care
- Integrated care delivery
- Diagnostic and ancillary services
- Surgery, and Invasive Procedures
- Medication management and safety
- Environmental and facility safety
- Infection prevention and control
- Organization governance and management
- Community assessment and involvement
- Workforce management
- Information management and technology
- Quality and performance improvement

NB. More than one requirement can be included in one document.

Standard Code & Keyword	Kind of document	Components
1- Patient centeredness culture:		
Related EQRs: **EQR.01: Patient and family education process** **EQR.03: Complaints and suggestion**		
PPC.01 Multidisciplinary patient-centeredness	Approved document	A multidisciplinary committee with clear terms of reference.
PCC.02 Patient and family rights	Policy	a) Patient and family rights as defined by laws, regulations, and the ethical code of healthcare professionals' syndicates. b) Patient and family rights to access care if provided by the universal health coverage. c) Patient and family rights to know the name of the responsible staff member. d) Patient and family rights to access care that respects the patient's personal values, beliefs, choices and patient preferences. e) Patient and family right to be informed and participate in making decisions related to their care. f) Patient and family rights to refuse care and discontinue treatment. g) Patient and family rights to security, personal safety, privacy, confidentiality, and dignity. h) Patient and family rights to have pain assessed and managed. i) Patient and family rights to make a complaint or suggestion without fear of retribution. j) Patient and family rights to know the price of services and procedures.
PCC.03 Patient and family responsibilities	Policy	a) Patients and their families have the responsibility to provide clear and accurate information on the current and past medical history. b) Patients and their families have the responsibility to comply with the policies and procedures of the PHC. c) Patients and their families have the responsibility to comply with financial obligations according to laws and regulations. d) Patients and their families have the responsibility to show respect to other patients and healthcare professionals. e) Patients and their families have the responsibility to follow the recommended treatment plan.
PCC.05 Recorded Informed consent	Policy	a) Informed consent for certain medical processes I. The list of medical processes when informed consent is needed; this list shall include: i. Simple invasive procedures. ii. Dental extractions. iii. Family planning interventions.

		iv. Photographic and promotional activities, for which the consent could be for a specific time or purpose. v. Pregnant women in case of radiological examination in medical necessity that justifies radiological examinations. II. The likelihood of success and the risk of not doing the procedure or intervention, benefits, and alternatives to performing that particular medical process. III. Certain situations when consent can be given by someone other than the patient, and mechanisms for obtaining and recording it according to applicable laws and regulations and approved PHC policies. IV. Required staff training on obtaining informed consent. V. Consent forms are available in all relevant locations. VI. Consent validity. b) Informed consent in case of refusing care or discontinuing treatment against medical advice (AMA). I. Patient and family refusal of medical care process is documented. II. Patient and family are informed about current medical condition. III. Patient and families are informed of the consequences of their decision. IV. Patient and families are informed about available care and treatment alternatives.
PCC.08 Patient's belongings	Policy	a) Determine the PHC's level of responsibility for patient belongings. b) How patients and families are informed about the PHC'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' property is returned? e) How the PHC will manage lost and found situations. The PHC shall define a clear process to follow when items are not returned within a defined timeframe.
PCC.09 Patient and family feedback	Policy	a) Measuring feedback for ambulatory patients. b) Measuring feedback for emergency patients.
2- Access, continuity, and transition of care:		
Related GSRs: **GSR.01: Patient identification** **Related EQRs:** **EQR.04: Granting access** **EQR.05: Referral process**		
ACT.02 Registration process	Policy	a) Establishing a PHC-wide scope of service that meets the universal health insurance package of services. b) Minimum information needed to register the patient, such as demographic data.

		c) Registration process and flow of patients are visible to patients and families at the point of the first contact and in public areas. d) Registration procedures.
ACT.04 Patient flow risks.	risk assessment document	Risk assessment for patient flow
ACT.05 Patient care responsibility	Policy	a) A list of families assigned to the PHC unit as per laws and regulations. b) Each family is assigned to one family health physician. c) Rules to be followed in case of absence/inability to assign a family health physician to every family. d) Conditions to request and grant transfer of care responsibility. e) How information about patient's condition and care plan shall be transferred from one physician to the next one. f) The process to ensure clear identification of responsibility between "transfer of responsibility" parties.
ACT.08 Patient Transportation	Policy	a) Safe patient handling to and from examination bed, troll wheelchair, and other transportation means. b) Staff safety while lifting and handling patients. c) Competence of responsible staff members for transportation of patients. d) Defined criteria to determine the appropriateness of transportati needs.
ACT.10 Telemedicine	program	a) Define the scope of services and the technological modalities used. b) The appropriate telemedicine platforms, mobile or internet–based applications, and other peripheral devices to be used in accordance with recommended industry guidelines. c) The resources required to sustain the planned telemedicine clinical services based on program goals. d) The training required for employees, participating providers, and other technical personals specific to telemedicine services. e) The process of overseeing outsourced telemedicine services or functions. f) The facility provides a clear method for the patient to initiate an encounter for telemedicine services. g) The process to verify and document patient/provider identities and physical locations for each telemedicine encounter. h) Adheres to generally accepted evidence-based guidelines relevant to the clinical services used for patient encounters. i) The process for referring patients to direct patient care, if indicated, based on objective and physiologically based criteria. j) The process of ensuring the privacy and cybersecurity of protected health information (PHI) in accordance with applicable laws and regulations. k) Periodical evaluation of telemedicine services based on quality indicators, including access, effectiveness, and satisfaction.

3- Integrated care delivery:

Related GSRs:

GSR.02: Verbal and telephone orders
GSR.03: Critical results
GSR.04: Fall screening and prevention

Related EQRs:

EQR.06: Cardiopulmonary resuscitation
EQR.07: Immunization program
EQR.08: Pediatric immunization program
EQR.09: Adult immunization program
EQR.10: Child health program
EQR.11: Maternity health program
EQR.12: Reproductive health program

ICD.01 Uniform Care	Policy	PHCs should have a policy that specifies what constitutes uniform care and what practices shall be followed to ensure that patients are not discriminated against based on their background or category of their accommodation.
ICD.03 First visit health assessment	Policy	A policy and procedures to define the contents and the time frame to complete the initial assessment. The Contents of the initial assessment shall include at least the following: a) Patient demographics b) Social screening c) Family data d) Family history e) Past history, including hospitalization and surgical history f) Nutritional risk and needs g) Functional/rehabilitation risk and needs h) Psychological screening i) Physical examination (review of all systems) j) The investigation required according to the guidelines k) Conclusion or clinical impression
ICD.04 Patient medical assessments, family health clinic visit's sheet	Policy	A policy and procedures to define the minimum acceptable contents of the family health clinic visit sheet and the frequency of needed follow-up visits. The visit assessment shall include at least the following: a) Chief complaint. b) Details of the present illness. c) Past history of medications; adverse drug reactions; allergies; social, emotional, behavioral, and family history; previous hospitalizations; surgery; and invasive procedures. d) Any diagnosis made. e) Investigations. f) Significant findings.

		g) The name and signature of the physician.
ICD.05 Patient nursing assessment	Policy	A policy to define the minimum acceptable contents of nursing assessments. The initial nursing assessment record shall include at least the following: a) Vital signs. b) Pain. c) Additional measurements such as height and weight. d) Risk assessments. e) A detailed nursing assessment of a specific body system(s) relating to the presenting problem or other current concern(s) is required.
ICD.06 Oral healthcare	Policy	a) Defining patient groups who can receive oral health services. b) Initial assessment requirements for oral health. c) Identifying high risk patients who needs proper medical management before undergoing dental procedures such as diabetics, patients on anticoagulation therapy, patients with infections and other patients. d) Planning oral healthcare. e) Management of potential complications.
ICD.09 Pain screening, assessment, and management	Policy	a) Pain screening tool(s). b) Complete pain assessment elements that include nature, site, and severity. c) Frequency of pain reassessments. d) Pain management protocols.
ICD.12 Emergency services	Policy	a) Trained staff members are available during working hours. b) Defined criteria are developed to determine the priority of care according to a recognized triage process. c) Assessment, reassessment, and care management follow approved clinical guidelines. d) The medical records of emergency patients should include at least the following: i Time of arrival and time of departure ii The medical and nurses' assessment and reassessmer iii The care provided. iv Conclusions at the termination of treatment v Patient's condition at departure vi Patient's disposition at departure vii Follow-up care instructions viii departure order by the treating medical staff member
ICD.20 Non-communicable diseases	policy	a) Identifying risk groups in the community related to non-communicable diseases. b) Setting targets for i. Reduction of tobacco consumption. ii. Reduction of the average delay in the diagnosis of non-communicable diseases by the PHC. iii. Early detection of hereditary diseases.

		iv. Reduction of the risk of heart attacks, strokes, amputations, and kidney failure. v. Reduction of case fatality of major non-communicable diseases. vi. Prevention of acute events and complications. vii. Prolongation of the duration of stable clinical periods of coronary vascular diseases, diabetes, asthma, and chronic obstructive pulmonary disease patients. c) Developing registers for patients in the catchment area that can be enrolled in the program. d) Provide education for registered patients. e) Following up with registered patients to ensure compliance with treatment plans and progress.
ICD.21 Special-needs patient populations	policy	a) Identification of special-needs patient populations that should include at least the following: i. Adolescents ii. Elderly iii. Disabled iv. Immunocompromised v. Patients with communicable diseases vi. Patients with chronic pain vii. Victims of abuse and neglect b) Required modifications for regular patient assessment methods to match special patient populations needs. c) Management and care of special patient populations needs through an individualized plan of care.
4-Diagnostic and ancillary services:		
Related GSRs: **GSR.05: Radiation Safety Program.** **GSR.06: Laboratory Safety Program** **Related EQRs:** **EQR.13: Medical imaging technical standards** **EQR.14: Laboratory technical procedures**		
DAS.06 Reagent management	**Policy**	a) Criteria for inspection, acceptance, and rejection of provided reagent. b) Methods of identification, enlisting, and labeling of all reagents present in the laboratory. c) Method to evaluate reagent quality to ensure its validity. d) Measures to ensure that the laboratory does not use expired materials. e) Good storage conditions of reagents and consumables. f) Define safety limits for the reordering of the laboratory materials according to the laboratory needs. g) Requesting, issuing, and dispatching reagents and supplies as well as identifying responsible persons.

DAS.06 Reagent management	**Updated list**	An updated list of all reagents and supplies that are used for all testing processes.

5-Surgical and Invasive Procedures

Related GSRs:

GSR.07: Surgical Site Marking
GSR.08: Pre-operative Checklist
GSR.09: Time out

6- Medication management and safety

Related GSRs:

GSR.10: High-risk medications
GSR.11: Look-alike and sound-alike medication
GSR.12: Medication reconciliation, best possible medication history (BPMH)
GSR.13: Medication storage, medication labelling, multiple dosing Medication

Related EQRs:

EQR.15: Life-supporting medications

MMS.01 Medication management, Pharmacy and Therapeutic Committee (PTC).	Program	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
MMS.02 Antimicrobial Stewardship Program	Program	The PHC has an approved multidisciplinary antimicrobial stewardship program based on national and/or international protocols, guidelines, and regulations..
MMS.03 Medication Procurement, Formulary, medication storage	list	The formulary shall include, but not be limited to, the following: a) Names of medications. b) Strengths/concentrations of medication(s). c) Dosage forms of the medication(s). d) Indications for use. e) Most common side effects of the medications

MMS.08 Medication recall, expired medications, outdated medications.	Policy	a) The process to retrieve recalled medications. b) Labeling and separation of recalled medications. c) Patient notification (when applicable). d) Disposal or removal.
MMS.10 Medication ordering, medication prescribing	Policy	a) The healthcare provider(s) who is/are authorized to prescribe medications. b) The uniform location in the patient's medical record to order and prescribe medications. c) The prohibition of the transcription process. d) Listing of prescribed medications including the following. i. Patient's identifications ii. Patient's demographics iii. Medication name. iv. Dosage form v. Strength or concentration vi. Dosage and frequency vii. Route of administration viii. Rates of administration (when intravenous infusions are ordered for emergency use) ix. Indications for use for PRN medications x. Date and time of the order. xi. Prescriber's identification e) The process to manage special types of orders, such as weight-based dosing, emergency order, or orders needs titration, tapering orders. f) The process to manage medication orders that are incomplete, illegible, or unclear medication orders. g) The process to manage prescription refills of chronic medications.
MMS.13 Medication errors, near misses, medication therapy problems	Policy	The PHC has an approved policy to guide the process of defining, reporting, analysing and acting on medication error(s), near miss(es), and medication therapy problem(s) based on national/international references.
7- Environmental and Facility Safety		
Related GSRs: **GSR.14: Fire and smoke safety** **GSR.15: Fire drills** **GSR.16: Hazardous materials safety** **GSR.17: Safety Management Plan** **GSR.18: Medical Equipment Plan** **GSR.19: Utilities Management Plan**		
EFS.05 **Smoking-Free Environment**	Policy	The policy should include any exceptions, penalties, and the designated smoking area outside the building.

EFS.07 Pre-Construction risk assessment	Risk assessment	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.
EFS.09 Security Plan	Plan	a) Security risk assessment. b) Identification of staff, patients, families,visitors, and vendors with the restriction of their movement within the PHC c) Identification of restricted areas d) Vulnerable patients such as the elderly, infants, those with mental disorders, and handicapped should be protected from the abuse and above-mentioned harms. e) Drill for child abduction should be performed at least biannually to ensure child protection. f) monitoring of remote and isolated areas. g) Workplace violence management (Any harm, such as violence, aggression, infant/child abduction) h) Staff training as regard security requirements. i) The plan is evaluated and updated annually and/or when required.
EFS.12 Disaster Plan	plan	a) Communication strategies: Internal communication may be in the form of Clear call tree that includes staff titles and contact numbers, and External communication channels may include civil defence, ambulance centre, police. b) Clear duties and responsibilities for PHC leaders and staff. c) Identification of required resources such as utilities, medical equipment, medical, and nonmedical supplies, including alternative resources. d) Business Continuity: i. Triaging. ii. Staff main task is maintained in case of emergencies: management of clinical activities during a disaster such as basic daily activities. iii. Alternative care sites, and back-up utilities. iv. Safe patient transportation in case of emergency is arranged by the PHC e) Risk assessment of potential emergencies, internal and external disasters, such as heavy rains, earthquakes, floods, hot weather, wars, bomb threats, terrorist attacks, traffic accidents, power failure, fire, and gas leakage. f) Drill schedule
EFS.13 Environmental Sustainability, Green Healthcare	Policy	a) Leadership Commitment: Leaders demonstrate commitment to environmental sustainability by including it in PHC policies, PHC leadership ensuring resource allocation. b) Employee Engagement: including activities to raise awareness, train staff on climate change and environmental practices, and encourage participation in eco-friendly initiatives.

		c) Proper resource allocation: develop and implement a plan to monitor and reduce the use of materials and environmental resources like energy, water, and reducing unnecessary supplies use. d) Waste Management: establish a comprehensive waste management hierarchy that prioritizes waste reduction and proper segregation. e) Green Infrastructure: considers opportunities for green infrastructure solutions through prioritizing natural lighting, avoid unnecessary outside lighting, use efficient led bulbs, use lighting with motion sensors. Optimizes energy use through efficient use air conditioning system on (24°C) and after-working hours' equipment shutdowns if applicable. Water-saving fixtures further enhance sustainability. f) Monitoring through Regular rounds to check the commitment to environmental Sustainability activities and evaluating the effectiveness of implemented strategies and activities.
8- Infection Prevention and Control		
Related GSRs: **GSR.20: Hand Hygiene** **Related EQRs:** **EQR.17: Disinfection, Sterilization**		
IPC.02 IPC program, risk assessment, guidelines	Program	a) Scope and objectives, b) Infection control policies and procedures such as hand hygiene. c) Risk assessment to identifies units and services with increased potential risk of infection, d) Staff education and training on infection control principles and practices, e) Outbreak management f) Staff immunization g) Antimicrobial stewardship program to promote the appropriate use of antimicrobial agents. h) The program is evaluated and updated regularly and when needed at least annually.
IPC.09 Laundry service, textile	Policy	a) Processes of collection and storage of contaminated textile. b) Cleaning of contaminated textile. c) Water temperature, detergents, and disinfectants usage. d) Processes of storage and distribution of clean textile. e) Quality control program (temperature, amount of detergents and disinfectants used, and maintenance) for each washing machine.
9- Organization Governance and Management		

Related EQRs: **EQR.18: Governing body structure and responsibilities**		
OGM.02 PHC Director	approved job description	a) Providing oversight of day-to-day operations. b) Ensuring clear and accurate posting of the PHC's services and hours of operation to the community. c) Ensuring that policies and procedures are developed and implemented by staff. d) Providing oversight of human, financial, and physical resources. e) Annual evaluation of the performance of the PHC's committees. f) Ensuring appropriate response to reports from any inspecting or regulatory agencies, including accreditation. g) Ensuring that there is a functional, organization-wide program for performance improvement, patient safety, and risk management with appropriate resources. h) Setting a framework to support coordination within and/or between departments or units, as well as a clear process of coordination with relevant external services. i) Regular reports to the governing body on how legal requirements are being met.
OGM.03 Clinical governance program	program	a) Clinical services based on clinical programs and guidelines. b) Monitoring of clinical services and clinical outcomes. c) The incident reporting system. d) Clinical risk management strategies. e) Encouraging a patient-centered culture. f) Staff training and ensuring their competence in clinical practices.
OGM.04 PHC leaders	approved job description	a) Sustaining a firm PHC structure: i. Collaboratively developing a plan for staffing the PHC that identifies the numbers, types, and desired qualifications of staff. ii. Providing appropriate facilities and time for staff education and training which should be tailored to serve both the PHC and staff needs through an iterative process of need assessment, planning, implementation, and evaluation. iii. Ensuring all required policies, procedures, and plans have been developed and implemented. iv. Selecting equipment and supplies based on defined criteria that include quality and cost-effectiveness. b) Running smooth directed operations: i. Creating a safe and just culture for reporting errors, near misses, and complaints, and use the information to improve the safety of processes and systems; a safety culture within the PHC is essential where staff feel confident when reporting on a safety incident that they will be treated fairly, in a confidential manner, and that the information they provide will be used to improve the care process and environment. ii. Designing and implementing processes that support continuity, coordination of care, and risk reduction.

		iii. Ensuring that services are developed and delivered safely according to applicable laws and regulations and approved strategic plans with input from the users/staff. c) Continuous monitoring and evaluation: i. Ensuring that all quality control monitoring is implemented and monitored and that action is taken when necessary. ii. Ensuring that the PHC meets the conditions of facility inspection reports or citations. iii. Annually assessing the operational plans of the services provided to determine the required facility and equipment needs for the next operational cycle. iv. Annually reporting to the PHC 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 PHC data are reviewed, analyzed, and used by management for decision-making. d) Continuous Improvement.
OGM.05 Strategic Planning	plan	The PHC has a strategic plan with goals and defined objectives.
OGM.06 Operational Planning	plan	a) Clear goals and objectives (SMART objectives). b) Specific activities and tasks for implementation. c) Timetable for implementation. d) Assigned responsibilities. e) Sources of the required budget.
OGM.07 Stock management	Policy	a) Compliance to storage laws, regulations, and organization policies. b) Management of stocks safely and efficiently. c) Inventory management and tracking 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 or not acceptance criteria were met and if any follow-up. iv. Date placed in service or disposition, if not used.
OGM.08 Billing system	Policy	a) Availability of an approved price list. b) Patients are informed of any potential cost pertinent to the planned care. c)Process to ensure accurate billing. d)Use of accurate and approved codes for diagnoses, interventions, and diagnostics.
OGM.09 Contract management	Policy	The PHC has an approved policy and procedures for the selection, evaluation, and continuous

OGM.09 Contract management	Approved list	A list of all contracted services, including provided services.
OGM.10 Ethical management	Policy	a) Developing and implementing the code of ethics. b) Developing and implementing PHC values. c) Handling Medical errors and medico-legal cases Identifying and disclosing conflict of interest. d) Management of discrimination and harassment. e) Management of ethical dilemma that may arise, including reporting methods, resolving timeframe and communicating the results to impacted stakeholders. f) Ensuring gender equality.
OGM.11 Positive Workplace Culture	Policy	a) Workplace cleanliness, safety, and security measures. b) Management of workplace violence, discrimination, and harassment. c) Communication channels between staff and PHC leaders. d) Staff feedback measurement, including suggestions for provided services improvement. e) Planning for staff development.
OGM.13 Staff Health	Program	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, such as: i. Ergonomic hazards that arise from the lifting and transfer of patients or equipment, strain, repetitive movements, and poor posture. ii. Physical hazards such as lighting, noise, ventilation, electrical, and others. iii. Biological hazards from blood borne and airborne pathogens and others. e) Staff education on the risks within the PHC environment as well as on their specific job-related hazards. f) Positive health promotion strategies, such as smoking cessation or encouraging physical activity. g) Scheduling of regular staff vaccination (on a regular basis and as indicated). h) Recording and management of staff incidents (e.g., injuries or illnesses, taking corrective actions, and setting measures in place to prevent recurrences). i) Periodic specific medical evaluation (tests and examinations) is required for staff members (as indicated) to evaluate their appropriateness for safe performance. The situational examination may be required in case of exposure to specific substances. Results of the medical evaluation are recorded in staff health records, and action is taken when there are positive results, including employee awareness of these results and provision of counseling and interventions as might be needed.

		j) Infection control staff shall be involved in the development and implementation of the staff health program as the transmission of infection is a common and serious risk for both staff and patients in healthcare facilities. k) All staff occupational health program-related results (medical evaluation, immunization, work injuries) shall be recorded and kept according to laws and regulations.
11- Community Assessment and Involvement		
CAI.01 Community profile	Approved document	Documents that defining the PHC catchment area include: Local population data that may include demographics, health status, health determinants
CAI.01 Community profile	Approved document	Agreement or official request letter of collaboration with those agencies that can make changes happen.
CAI.02 Planning for community involvement	program	a) Identification and description of the catchment area. b) Health needs assessment should include: i. Accessibility and timeliness of services. ii. Risk assessment of the community hazards including environmental problems. iii. Healthcare needs. iv. Healthcare education needs. v. Healthcare expectation. c) Planning to provide or update the package of services provided based on needs assessment. d) Planning for interventions. e) Identifying potential solutions. f) Announcing or posting selected solutions to the community. g)Training tools and information provided for the community activities.
CAI.03 PHC advertisement	Policy	The PHC has an approved policy guiding the process of providing clear, updated and accurate advertisement of services.
CAI.04 Health education	program	a. Heath education needs and problems. b. Target groups for health education. c. Methods of health education. d. Health messages. e. Health educators and supportive groups. f. Timetables. g. Communication channels with local community h. How the program be conducted inside and outside the PHC. i. Evaluation tool.
CAI.05 Proper nutrition	program	a) Identification of local nutritional problems and priority needs. b) Target groups. c) Promotion of breastfeeding. d) Micronutrients and food supplementation. e) Nutritional education needs. f) Required training for the involved staff.

		g) Monitoring of the program outcomes using key outcome indicators (BMI, cholesterol level, blood pressure, etc.).
CAI.06 Surveillance and reporting	policy	a) List of communicable and endemic reportable diseases. b) Case definitions of communicable and endemic diseases. c) Detection of signs and symptoms of disease in exposed persons. d) Management protocols and reporting requirements. e) Early isolation, evaluation, and treatment of secondary cases to ensure effective control of disease and prevention of its further transmission.
CAI.07 Safe water supply	procedure	There is a written procedure that defines how to monitor safe water supply and environmental sanitation including collaboration with other authorities to maintain safe water supply and environmental sanitation.
12- Workforce Management		
Related EQRs: **EQR.19: Staffing plan** **EQR.20: Staff files** **EQR.21: Orientation program**		
WFM.02 Job description	Approved document	Job descriptions include the requirements (license, certification or registration, education, skills, knowledge, and experience) and responsibilities of each position.
WFM.03 Recruitment	Policy	a) Collaboration with service/unit 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.
WFM.06 Continuous Education Program	Program	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 PHC. 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, cultural beliefs, needs and activities of different groups served. l) Defined abuse and neglect criteria. m) Medical equipment and utility systems operations and maintenance.
WFM.07 Staff Performance Evaluation	Approved document/ tool	PHC shall use a performance evaluation tool to ensure staff have the required criteria for doing jobs and achieving objectives.
WFM.07 Staff Performance Evaluation	Approved document/ tool	Performance evaluation of medical staff members addresses certain criteria that include those related to patient's medical record documentation and medication use, such as: a) Reviewing patient's medical record for completeness and timeliness. b) Utilization practice and medication use. c) Compliance with approved clinical guidelines. d) Complications, outcomes of care, mortality, and morbidity. e) Professional development.
WFM.08 Clinical Privileges	Policy	a) Medical staff members and independent practitioners with clinical privileges are subject to bylaws. b) Privileges indicate if the medical staff can treat patients. c) Privileges define the scope of patient care services and the types of procedures they may provide in the PHC. d) Privileges are determined based on documented evidence of competency (experience qualifications – certifications-skills) that are reviewed and renewed at least every three years. e) Privileges are available in areas where medical staff provides services pertinent to granted privileges. f) Medical staff members with privileges do not practice outside the scope of their privileges. g) When medical staff are granted a privilege under supervision, clinical privileges address the accountable supervisors, mode, and frequency of supervision.
13- Information Management and Technology		
Related GSRs: **GSR.29: Use of symbols and abbreviations** **Related EQRs:** **EQR.23: Medical record management** **EQR.24: Downtime of data systems**		
IMT.01 Information management plan	Plan	a) The identified information needs of clinical and managerial PHC leaders. b) The information needs and requirements of external authorities and agencies. c) The size and type of services provided by the PHC. d) Critical processes where recording is mandated.

		e) Clinical coding (diagnosis and procedure codes) matching those provided by health authorities and/or third-party payers. f) Staff training according to their responsibilities, job descriptions, and data and information needs
IMT.02 Document control system.	Policy	a) Standardized formatting. b) Document control system for tracking of issues and tracking of changes. c) The system allows each document to be identified by title, date of issue, edition and/or current revision date, the number of pages, who authorized issue and/or reviewed the document and identification of changes of version. d) Required policies, procedures, plans, programs, and guidelines are available and disseminated to relevant staff. e) Staff understand how to access those documents relevant to their responsibilities. f) Retirement of documents. g) Policies revisions
IMT.04 Confidentiality and Security of data	Policy	a) Procedures to ensure privacy, confidentiality, and security of data. b) Determination of who can access which type of data and information. c) The circumstances under which access is granted. d) Confidentiality agreements with all those who have access to patient data. e) Procedures to ensure privacy and cybersecurity of patient information. f) Procedures to follow if confidentiality or security of information has been breached.
IMT.06 Retention of Data and Information	Policy	a) Retention time for each type of document. b) Information confidentiality shall be maintained during the retention time. c) Mechanism to identify records that shall be archived. d) Retention conditions, archival rules, data formats, and permissible means of storage, access, and encryption. e) Data destruction procedures.
IMT.08 Patient's medical record usage**.**	Policy	a) Individuals who are permitted to make entries in the patient's medical record. b) Process to ensure that only authorized individuals make entries in medical records, and each entry identifies the author, date, and time of entry. c) Process to define how entries in the patient's medical record are corrected or overwritten.
IMT.09 Medical Record Review process	Policy	a) Review of a representative sample of all services. b) Review of a representative sample of all disciplines/staff. c) Involvement of representatives of all disciplines who make entries. d) Review of the completeness and legibility of entries. e) Review occurs at least quarterly.

		f) Random sampling and selecting approximately 5% of patients' medical records.
14- Quality and Performance Improvement		
Related EQRs: **EQR.25: Incident reporting system** **EQR.26: Sentinel events**		
QPI.01 Quality improvement Plan.	Plan	a) The goal(s) of the plan that fulfils the PHC's mission. b) Defined responsibilities of improvement activities. c) Data collection, data analysis tools, and validation process. d) Defined criteria for prioritization and selection of performance improvement projects. e) Quality improvement model(s) used. f) Information flow and reporting frequency. g) Training on quality improvement and risk management approaches. h) Regular evaluation of the plan (at least annually).
QPI.02 Performance Measures	list	a) Average waiting times in the relevant service areas. b) Patient's medical record availability. c) Patient's medical record completeness. d) Screening for communicable diseases. e) Screening for non-communicable diseases. f) Health education. g) Immunization. h) Medication errors, near-misses, and adverse outcomes. i) Patient and family satisfaction rates. j) Patient complaints. k) Staff satisfaction. l) Staff complaints. m) Procurement of routinely required supplies and medications. n) Staff performance. o) GAHAR safety requirements p) Facility management.
QPI.03 Data collection, review, aggregation and analysis	Approved Document	Approved document of data management that includes a) Data collection. b) Data aggregation. c) Data analysis and identify trends.
QPI.04 Data validation**.**	Approved document	A written process for data review and validation
QPI.05 Risk Management Program	Program/ plan	a) Scope, objective, and criteria for assessing risks. b) Risk management responsibilities and functions. c) Policies and procedures support PHC risk management framework. d) Staff training on risk management concepts and tools. e) Risk identification including, risk register. f) Risk prioritization and categorization (i.e., strategic, operational, reputational, financial, other).

		g) Risk Reduction plans and tools with priority given to high risks. h) Risk reporting and communication with stakeholders and governing body. i) The risk management program/plan is updated annually.
QPI.08 Sustained improvement activities	Approved document	Approved document written methodology for improvement