ASF AMBULATORY CLINIC STANDARDS

Complete Reference — Base Standard + 18 Endorsements

Version 3.0 · 2026

Accréditation Sans Frontières · Paris, France · Geneva, Switzerland · Tbilisi, Georgia

Document Control

Document Title	ASF Ambulatory Clinic Standards
Document Reference	ASF-AMB-STD3-v3.0
Version / Edition	Version 3.0
Status	Published
Date of Publication	12 September 2026
Place of Publication	Paris, France
Issuing Authority	ASF International Standards Council, Accréditation Sans Frontières
Language of Origin	English
Effective Date	12 September 2026
Next Scheduled Review	12 September 2029
Supersedes	Version 2.0 and earlier editions

Foreword

This standard originates from a deliberate policy choice made in Georgia in 2014: to advocate for international healthcare accreditation rather than attempt to replace it. Working through the Public Health Institute of Georgia (PHIG, established 2011), its founders organized the country's first structured accreditation initiative — including expert missions by Joint Commission International — and carried this advocacy directly to Georgia's Ministry of Health over the following years.

That advocacy produced, in 2018, the first draft of a Georgian-adapted accreditation standard, and in 2020, the formal establishment of Accréditation Sans Frontières (ASF) as an international legal entity in Paris, alongside the ASF International Standards Council — the standing body responsible for developing and revising ASF's standards. The Council's methodology is directly informed by the World Health Organization's guideline development process, including WHO's use of the GRADE framework for weighing evidence certainty, adapted to the practical work of accreditation. ASF's founder has served since 2016 as a founding member of the UN Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent, and ASF has been a member of the International Society for Quality in Health Care (ISQua) since 2023.

This advocacy also found regulatory validation in Georgian government policy requiring independent international accreditation of hospitals, formally implemented through Order №4/б (26 January 2023).

Consistent with the structure recognized across major international standards bodies, ASF's work spans four pillars: accreditation of organizations against its published standards, accreditation of the standards themselves through the International Standards Council's ongoing review, accreditation of the surveyors who conduct ASF's own assessments, and accreditation of the training that equips facilities and professionals to meet them, delivered through GMJ Academy. This standard has been developed and refined through consultation with practitioners across multiple continents, and every edition includes a Health & Migration endorsement grounded in WHO's Global Competency Standards for health workers serving refugees and migrants — a commitment ASF treats as non-negotiable. Consistent with ASF's founding principle of accreditation without borders, this standard is published in full and made freely available to any organization seeking to build accreditation capacity in its own country.

This, the third edition, is published in 2026. The ASF International Standards Council reviews and revises each standard on a three-year cycle.

About This Document

This is the ASF Ambulatory Clinic complete standard — seven mandatory base standards covering the core patient journey through any outpatient medical facility, independent of specialty, plus eighteen built endorsements layering onto that base for specific specialties and populations: Dental, Aesthetic & Injectable Medicine, Longevity & IV Therapy, Oncology & Infusion Therapy, Dialysis & Renal Replacement Therapy, Fertility & IVF, Cardiology & Cardiac Catheterization, Ophthalmology & Day Surgery, Diagnostic Imaging, Dermatology, Allergy & Immunotherapy, Plastic & Cosmetic Surgery, Psychiatry & Mental Health, Narcology & Addiction Treatment, Gastroenterology & Endoscopy, Pediatric Ambulatory Care, Medical Tourism, and Refugee & Migrant Health. No endorsement is ever issued alone — each is only assessed after the base standard is genuinely met in full.

Every criterion follows the same two-page structure established across ASF's standards: an assessment page (a clinic self-assessment table, and exactly what an ASF assessor will independently check) and a guidance page (why the standard exists, what good and failure look like, how to implement from zero).

Every criterion carries at least one reference. Numbered references are formal, individually verified Vancouver-style citations; where a criterion instead reflects genuine professional consensus without one attributable paper, that is stated honestly rather than assigned an invented citation.

Immediately after this page is the Facility Classification chapter — the same four-type model already established for ASF's Hospital standard, adapted for ambulatory clinics specifically: Crisis, Transitional, Small, or Standard.

Alignment With ISO 9001:2015

This standard's governance structure — Standard 7 — is deliberately built to reflect the core management principles of ISO 9001:2015, the international quality management system standard [7]. This is a statement of structural alignment, not a claim of certification: ISO 9001:2015 compliance is a formal status determined only through accredited external audit, which this document does not confer. The table below shows the mapping honestly, clause by clause.

ISO 9001:2015 CLAUSE	WHERE THIS STANDARD REFLECTS IT
Clause 4 — Context of the Organization	Not directly covered — outside this standard's clinical patient-safety scope.
Clause 5 — Leadership	7.1 — Leadership Is Real and Accountable
Clause 6 — Planning	3.4 (Risk Register) and 7.8 (Quality Objectives Are Set, Specific, and Tracked)
Clause 7 — Support	4.2 (Credentials), 7.4 (Records), 7.6 (Scope of Practice)
Clause 8 — Operation	Standard 4 (Care & Treatment) in full
Clause 9 — Performance Evaluation	7.7 — Leadership Reviews Overall Performance at Planned Intervals
Clause 10 — Improvement	7.5 (Incident Reporting) and 7.9 (Continual Improvement Process)

Facility Classification — Which Type of Ambulatory Clinic Are You?

Four Clinic Types, Not One

The same four-category model built for ASF's Hospital standard applies here, with one deliberate change: Small is no longer anchored to bed count, since ambulatory clinics don't have beds. The honest equivalent — confirmed directly — is clinical staff count.

Standard (ST)

A fully resourced, functioning ambulatory clinic — full diagnostic capability, broad specialist coverage, no adaptation needed.

Small (SM) — where staffing depth, not crisis or poverty, is the defining constraint

Fewer than five clinical staff is the confirmed anchor — otherwise stable, but genuinely limited by scale in what it can offer.

Transitional (TR)

Real national resource or infrastructure limitation, no active conflict — the same World Bank-anchored logic used throughout ASF's standards.

Crisis (CR)

Active conflict or humanitarian emergency — overrides every other consideration, exactly as in the Hospital standard.

The Universal Floor

A small number of criteria apply in full, in every one of the four types, with no exceptions: correct patient identification, genuine hand hygiene, real informed consent, dignity and non-discrimination, and — specific to ambulatory care — every test result reaching the patient regardless of type.

Which Type of Clinic Are You?

Answer these questions in order, top to bottom. The moment you answer YES, stop — that is your answer. If you reach the end still answering NO, you are Standard.

WORK DOWN THIS LIST. STOP AT YOUR FIRST YES.			
1	**Is your country in an active war, armed conflict, or a declared humanitarian emergency right now?** *This means fighting, displacement, or a declared emergency is actually happening now — not that things are generally difficult.*	☐ **YES → CR CRISIS**	☐ NO → next question
2	**Does your national government struggle badly to fund healthcare, or is national power or medicine supply unreliable — even though there is no war or crisis?** *This is about your country as a whole, not just your own clinic.*	☐ **YES → TR TRANSITIONAL**	☐ NO → next question
3	**Does your clinic have fewer than five clinical staff, and is that small size the main reason you cannot offer certain services?** *This applies even in a stable, well-funded country. The limit here is your own size, nothing else.*	☐ **YES → SM SMALL**	☐ NO → next question
If you answered YES to Small — specify your exact staff count: ☐ **Exactly 1 (MICRO — a genuine solo practitioner)** ☐ **2 to 5 (SMALL — a small group)** *Both are tagged SM on every criterion in this document. This distinction exists because the Adapted guidance on governance criteria speaks directly to whichever is genuinely true for you — a solo practitioner and a small team face different real questions about the same requirement.*			
If you answered NO to all three questions above: You are **STANDARD (ST)** — no crisis, no national constraint, and staffing depth is not holding you back.			

THIS IS ME
My type: ☐ **CR** ☐ **TR** ☐ **SM** ☐ **ST** **If SM:** ☐ **MICRO (1 clinical staff)** ☐ **SMALL (2–5 clinical staff)**

Example: A dental clinic in Lebanon — no active conflict, so NO to question 1. National power and funding are genuinely unreliable, so YES to question 2. Stop there. This clinic is TR.

Verified, not just accepted, on the assessor's visit. If reality is different from what you ticked, the classification is corrected on the spot.

Table of Contents

STANDARD 1

Access & Arrival

MANDATORY

4 criteria

	Standard 1.1 **NON-NEGOTIABLE** · *Standard 1: Access & Arrival* **Findable Before Arrival**	**ASSESSMENT** ASF-AMB-STD1-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

1.1
NON-NEGOTIABLE
L1

THE STANDARD

Findable Before Arrival

The clinic's name, address, phone number, and mapped location are correct, current, and independently verifiable by anyone searching as a patient would.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the clinic name, address, and phone number correct on your own website and any public listing?** *Not the address on file years ago — what a patient searching today would actually find.* Doc: Website screenshot, public listing	YES	PARTIAL	NO
2	**Does the phone number listed actually connect to your clinic when called?** *Tested directly, not assumed correct because it was correct when first published.* Doc: Call log or test record	YES	PARTIAL	NO
3	**If a map location is used, does the pin match the real entrance, not a nearby approximation?** *A pin one block off sends patients to the wrong door, or ambulances to the wrong street.* Doc: Map screenshot	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Public search test*	Independently searches for the clinic exactly as a patient would — by name, address, phone — using only public information.
DOCUMENT *Address cross-check*	Confirms the mapped or listed address matches what is physically found on arrival.
ASK *Cold-call directions test*	Calls the listed number posing as a first-time patient asking for directions, and notes whether the answer is accurate without hesitation.

REFERENCES

[1] World Health Organization. Emergency care system framework. Geneva: WHO; 2018.

Standard 1.1 · *Standard 1: Access & Arrival*

Guidance & Learning

GUIDANCE ASF-AMB-STD1-v3.0

WHY THIS STANDARD EXISTS

A clinic that cannot be found cannot be reached — a common, preventable failure that costs real time when a patient is trying to get care, or an ambulance is trying to find them for a home-to-clinic transfer.

The evidence: [1] World Health Organization. Emergency care system framework. Geneva: WHO; 2018.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Name, address, and phone number are correct and independently verifiable.	✗ An old address is still listed on letterhead, alongside a correct current one online.
✓ A patient can cold call and reach the clinic within a minute.	✗ Listed number rings out with no voicemail, no way to confirm this is the right place.
✓ The mapped pin matches the real, physical entrance exactly.	✗ A map pin one street over from the real building, with no correction requested.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The website was never updated after a move.**
The clinical team changed but nobody told whoever manages the website — a common, low-cost, high-consequence gap.

2 **The phone number is correct but nobody answers as "the clinic."**
Calls connect to a generic switchboard that cannot confirm this is the right place.

3 **The map pin was set once, years ago, and never checked again.**
Map platforms occasionally shift pins during their own updates — nobody at the clinic owns checking it periodically.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Search for your own clinic exactly as a patient would, across every platform patients actually use.

Week 2 Correct the address and phone number on your own website and any listing you control directly.

Week 3 Call your own listed number from an outside line and time how long it takes to confirm you've reached the right place.

Ongoing Recheck all public listings every six months.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Search cold, don't ask the clinic for directions first.
The whole point is testing what a stranger finds.

Call from a number the clinic won't recognise.
A number in the clinic's own contact list may get special handling a real patient wouldn't.

E-LEARNING academy.gmj.ge/amb-std1-1-findability — 30 min · complete before self-assessment

	Standard 1.2 **NON-NEGOTIABLE** · *Standard 1: Access & Arrival* **A Genuinely Usable Entrance for Disabled Patients**	**ASSESSMENT** ASF-AMB-STD1-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.2
NON-NEGOTIABLE
L1

THE STANDARD

A Genuinely Usable Entrance for Disabled Patients

At least one entrance is step-free or served by a compliant ramp, with a door wide enough for a wheelchair to pass through without difficulty and hardware operable with one hand. Where this does not yet exist, the clinic holds a specific, budgeted, dated plan to close the gap.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there at least one step-free entrance, or a ramp meeting a genuine healthcare-grade gradient, not a makeshift board?** *A steep improvised ramp can be more dangerous than stairs — this means a real, safe gradient.* Doc: Photo of entrance and ramp	YES	PARTIAL	NO
2	**Can a standard wheelchair pass through the entrance door without the user needing help to squeeze through?** *A specific, measurable width, not a visual impression that it looks wide enough.* Doc: Door width measurement	YES	PARTIAL	NO
3	**Where full access doesn't yet exist, is there a specific, dated, budgeted plan to fix it — not a general intention to "look into it eventually"?** *A plan with a number and a date, the same standard applied throughout this whole framework.* Doc: Written access improvement plan	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Physical entrance check*	Directly tests the entrance and ramp gradient, and attempts entry as a wheelchair user would.
DOCUMENT *Door width measurement*	Measures the actual clear door width against the healthcare-specific guideline threshold.
DOCUMENT *Access plan review*	Where full access doesn't exist, reviews the specific plan for a real budget and date, not a vague aspiration.

REFERENCES

[2] International Health Facility Guidelines. Part C — Access, Mobility and OH&S. Sydney: Health Facility Guidelines; and United Nations. Convention on the Rights of Persons with Disabilities. New York: UN; 2006. Article 9.

Standard 1.2 · *Standard 1: Access & Arrival*

Guidance & Learning

GUIDANCE ASF-AMB-STD1-v3.0

WHY THIS STANDARD EXISTS

Ambulatory clinics very commonly occupy repurposed ground-floor apartments or converted commercial units never originally designed as healthcare space — unlike a purpose-built hospital, physical accessibility here often has to be actively created, not assumed to already exist.

The evidence: [2] International Health Facility Guidelines. Part C — Access, Mobility and OH&S. Sydney: Health Facility Guidelines; and United Nations. Convention on the Rights of Persons with Disabilities. New York: UN; 2006. Article 9.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ At least one entrance is genuinely step-free or ramped to a safe healthcare-grade gradient.	✗ The only entrance has steps with no ramp alternative at all.
✓ The door is wide enough for a standard wheelchair to pass without assistance.	✗ A ramp exists but is too steep to be genuinely safe, effectively decorative.
✓ Where access doesn't yet exist, a specific, funded, dated plan is in place and visibly being followed.	✗ No specific plan exists — only a general acknowledgement that access "should be improved sometime."

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A ramp exists but was built to a residential, not healthcare-grade, gradient.**
A ramp steep enough for general use can still be unsafe for a wheelchair user managing it alone.

2 **The main entrance is accessible but a secondary or side entrance patients sometimes use is not.**
Accessibility needs to hold at whichever entrance a patient is actually directed to, not just the primary one.

3 **A plan exists but has no specific budget or date attached to it.**
An intention without a number and a date tends to stay an intention indefinitely.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Measure your actual entrance — door width, ramp gradient if one exists — against the healthcare-specific guideline.

Week 2 If full access isn't achievable immediately, write a specific plan with a real budget figure and completion date.

Week 3 If a temporary workaround is needed in the meantime, make it genuinely safe, not just present.

Ongoing Revisit the plan's progress against its own stated date.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Try to enter as a wheelchair user would, don't just look at the ramp.
A ramp that looks adequate can still be unsafe to actually use alone.

Ask for the specific budget figure and date in the access plan, not a general description of intent.
Specificity is what distinguishes a real plan from a good intention.

E-LEARNING academy.gmj.ge/amb-std1-2-disability-access — 30 min · complete before self-assessment

Standard 1.3 **NON-NEGOTIABLE** · *Standard 1: Access & Arrival*

Approach and Grounds Safety

ASSESSMENT ASF-AMB-STD1-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.3
NON-NEGOTIABLE
L1

THE STANDARD

Approach and Grounds Safety

The immediate approach to the clinic — parking area, entryway, path from the street — is safe, clean, and well lit, not merely the building interior once a patient has already arrived.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is the walkway from the street or parking area to the entrance free of trip hazards and adequately lit?** *Checked directly underfoot, not assumed safe because it looks fine from a distance.* Doc: Photo of approach, day and evening if relevant	YES	PARTIAL	NO
2	**Is the approach kept clear of obstruction — parked vehicles, stored materials, snow or ice where relevant?** *A route that's sometimes blocked is not a reliably safe route.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific, assigned responsibility for keeping the approach safe, not a general hope someone will notice a hazard?** *Specific ownership, not diffuse responsibility that belongs to nobody in particular.* Doc: Role assignment record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Approach walk-through*	Physically walks the entire approach from the street or parking area to the entrance, checking for hazards.
OBSERVE *Obstruction check*	Checks whether the approach is currently clear, and asks how recently it was last checked.
ASK *Responsibility interview*	Asks who is specifically responsible for approach safety and maintenance.

REFERENCES

[3] Ulrich RS, Zimring C, Zhu X, DuBose J, Seo HB, Choi YS, et al. A review of the research literature on evidence-based healthcare design. HERD. 2008;1(3):61-125.

Standard 1.3 · *Standard 1: Access & Arrival*

Guidance & Learning

GUIDANCE ASF-AMB-STD1-v3.0

WHY THIS STANDARD EXISTS

A patient's first real safety risk of the visit is often the walk from the street or car park to the door, particularly for elderly or mobility-impaired patients — a hazard here undermines everything the clinic does correctly once the patient is actually inside.

The evidence: [3] Ulrich RS, Zimring C, Zhu X, DuBose J, Seo HB, Choi YS, et al. A review of the research literature on evidence-based healthcare design. HERD. 2008;1(3):61-125.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The approach is free of trip hazards, well lit, and genuinely walkable.	✗ Uneven paving or poor lighting on the approach has never been addressed.
✓ The route stays consistently clear of obstruction.	✗ The entryway is regularly blocked by parked vehicles or stored equipment.
✓ A specific person or role owns approach safety and maintenance.	✗ Nobody can identify who is responsible for noticing or fixing a hazard on the approach.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The approach is well maintained during the day but poorly lit after dark.**
A hazard assessment done only in daylight can miss a genuine evening safety gap.

2 **Maintenance happens reactively after a complaint, not on any regular schedule.**
Waiting for a complaint means at least one patient experienced the hazard first.

3 **Responsibility is informally understood by long-term staff but not written down anywhere.**
Informal knowledge disappears the moment that staff member is unavailable or leaves.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Walk the approach yourself, including after dark if the clinic operates evening hours.

Week 2 Fix any immediate hazard found — lighting, uneven surface, obstruction.

Week 3 Assign specific, written responsibility for ongoing approach safety.

Ongoing Recheck the approach on a fixed schedule, not only after a complaint.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Walk the approach yourself rather than asking staff to describe it.
A route staff walk daily can become invisible to them even when a real hazard exists.

Ask specifically about evening conditions if the clinic has evening hours.
Daytime safety and evening safety are genuinely different conditions.

E-LEARNING academy.gmj.ge/amb-std1-3-approach-safety — 30 min · complete before self-assessment

Standard 1.4 **CORE** · *Standard 1: Access & Arrival*
Wayfinding Without Staff Dependence

ASSESSMENT ASF-AMB-STD1-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

1.4
CORE
L1

THE STANDARD

Wayfinding Without Staff Dependence

Basic wayfinding allows someone with no prior knowledge of the clinic to locate reception and the relevant waiting area without stopping to ask for directions more than once.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Can a first-time visitor find reception without asking for directions more than once?** *Tested directly by someone unfamiliar with the layout, not assumed from staff familiarity.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is signage clear and consistent, not relying on informal or outdated labels?** *Signage that matches how staff actually refer to a space, not a leftover label from a previous use.* Doc: Photo of signage	YES	PARTIAL	NO
3	**For a very small clinic where the whole space is visible from the entrance, is a lighter approach genuinely sufficient?** *A one-room clinic may not need formal signage at all — this asks whether that's a genuine fit, not an excuse.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *First-time visitor test*	Approaches as a first-time visitor would, checking whether reception can be found without repeated direction-asking.
OBSERVE *Signage consistency check*	Checks that signage is current, consistent, and matches actual space use.
ASK *Reception burden interview*	Asks reception staff how often they are asked basic directional questions during a typical day.

REFERENCES

[4] Carpman JR, Grant MA. Design that cares: planning health facilities for patients and visitors. 3rd ed. San Francisco: Jossey-Bass/Wiley; 2016.

Standard 1.4 · *Standard 1: Access & Arrival*

Guidance & Learning

GUIDANCE ASF-AMB-STD1-v3.0

WHY THIS STANDARD EXISTS

A confusing arrival sequence adds avoidable stress to a visit that may already be stressful for the patient, and forces reception staff to spend time on basic navigation questions instead of the tasks their role actually requires.

The evidence: [4] Carpman JR, Grant MA. Design that cares: planning health facilities for patients and visitors. 3rd ed. San Francisco: Jossey-Bass/Wiley; 2016.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A first-time visitor reaches reception without confusion.	✗ Visitors regularly get lost or need multiple directions from staff.
✓ Signage is current, clear, and consistently used.	✗ Signage is outdated, inconsistent, or missing at key decision points.
✓ Where the clinic is small enough that formal signage is genuinely unnecessary, this is a real fit, not a gap being excused.	✗ A larger, layout-complex clinic has no signage at all, relying entirely on staff to guide every visitor.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Signage exists for the main path but not for less obvious secondary routes.**
The most complex parts of a layout are exactly where clear guidance matters most.

2 **Signage was accurate when installed but hasn't been updated as rooms changed use.**
A label pointing to a room's old purpose actively misleads rather than helps.

3 **Reception staff have become so used to giving directions that the underlying confusion is normalised rather than fixed.**
Staff adapting to a problem isn't the same as the problem being solved.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Ask someone unfamiliar with the clinic to find reception unassisted and note where they hesitate.

Week 2 Add or correct signage at the specific points of confusion identified.

Week 3 Confirm with reception staff whether directional questions have genuinely decreased.

Ongoing Recheck signage accuracy whenever room use changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Use a genuinely unfamiliar person for the test, not clinic staff.
Staff familiarity makes it impossible to judge wayfinding as a real first-time visitor would experience it.

Ask reception staff directly how often they field basic directional questions.
A high frequency is itself evidence of a wayfinding gap, regardless of how staff have adapted to it.

E-LEARNING academy.gmj.ge/amb-std1-4-wayfinding — 30 min · complete before self-assessment

STANDARD 2

Reception & Information

MANDATORY

5 criteria

Standard 2.1 **NON-NEGOTIABLE** · *Standard 2: Reception & Information*

Patients Know Their Rights

ASSESSMENT ASF-AMB-STD2-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

2.1
NON-NEGOTIABLE
L1

THE STANDARD

Patients Know Their Rights

A patient rights charter exists, is visibly displayed, and patients can describe it in their own words — not a document filed away that nobody references.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a patient rights charter visibly displayed in the waiting area?** *Posted where a patient waiting would actually see it, not filed in an office.* Doc: Photo of displayed charter	YES	PARTIAL	NO
2	**Is the charter written in plain language, in the languages patients actually speak?** *A legal document patients can't parse doesn't meet this.* Doc: Charter text, all language versions	YES	PARTIAL	NO
3	**Can a patient asked directly describe at least one of their rights in their own words?** *Tests whether the charter reached them, not whether it exists.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Display check*	Checks whether the charter is genuinely visible in the waiting area.
ASK *Patient awareness test*	Asks a patient, unprompted, whether they know they have specific rights here.
DOCUMENT *Language coverage check*	Reviews which languages the charter covers against the patient population.

REFERENCES

[5] World Health Organization. Framework on integrated, people-centred health services. Geneva: WHO; 2016.

Standard 2.1 · *Standard 2: Reception & Information*

Guidance & Learning

GUIDANCE ASF-AMB-STD2-v3.0

WHY THIS STANDARD EXISTS

A rights charter that exists only in an office drawer protects nobody. Rights only function as rights if the person they protect knows they have them, in language they actually understand.

The evidence: [5] World Health Organization. Framework on integrated, people-centred health services. Geneva: WHO; 2016.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The charter is visibly posted in the waiting area, in the languages patients speak.	✗ The charter exists only in an office, never seen by patients.
✓ A patient asked directly can describe at least one specific right.	✗ Patients asked directly have no idea they have any specific rights.
✓ Staff can point to where the charter is displayed without hesitation.	✗ The charter exists in only one language in a multilingual patient population.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The charter is displayed but only in the majority language.**
A meaningful minority of patients may be functionally unable to read it.

2 **The charter is posted but written in legal or clinical language.**
Technically available and practically accessible are different things.

3 **Staff know the charter exists but have never actively explained it to a patient.**
Passive display rarely closes the awareness gap on its own.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Check current display location and language coverage.

Week 2 Rewrite in plain language if the current version is legal or clinical in tone.

Week 3 Translate into the languages your patients actually speak.

Ongoing Brief reception staff to actively reference the charter.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient directly, don't rely on staff description.
Staff describing the policy and a patient's actual awareness are different things.

Check language coverage against the actual patient population.
A single-language charter can look complete while failing a meaningful share of patients.

E-LEARNING academy.gmj.ge/amb-std2-1-patient-rights — 30 min · complete before self-assessment

Standard 2.2 **CORE** · *Standard 2: Reception & Information*

Pricing Is Disclosed Before Care Begins

ASSESSMENT ASF-AMB-STD2-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

2.2
CORE
L1

THE STANDARD

Pricing Is Disclosed Before Care Begins

Patients receive clear, written information about the cost of a service before treatment begins, in a form they can keep, not only on the final invoice.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is pricing disclosed before treatment begins, not only on the final invoice?** *Disclosure after the fact doesn't allow an informed decision.* Doc: Pricing disclosure sample	YES	PARTIAL	NO
2	**Is pricing given in writing the patient can keep, not only spoken once?** *A spoken mention easily forgotten is not the same as something to refer back to.* Doc: Written estimate	YES	PARTIAL	NO
3	**Can a patient describe roughly what they were told a service would cost?** *Tests whether the disclosure actually registered.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Disclosure timing review*	Reviews records for evidence pricing was disclosed before treatment, not only invoiced after.
OBSERVE *Written format check*	Checks pricing is provided in a retainable written form.
ASK *Patient recall check*	Asks a recent patient what they recall being told about cost beforehand.

REFERENCES

[6] World Health Organization. Tracking universal health coverage: financial protection global monitoring report. Geneva: WHO; 2021.

Standard 2.2 · *Standard 2: Reception & Information*

Guidance & Learning

GUIDANCE ASF-AMB-STD2-v3.0

WHY THIS STANDARD EXISTS

A patient who doesn't know the cost of care until the bill arrives cannot make an informed choice about their own treatment, and for an ambulatory visit that's often paid out of pocket at the point of care, this matters immediately, not eventually.

The evidence: [6] World Health Organization. Tracking universal health coverage: financial protection global monitoring report. Geneva: WHO; 2021.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Pricing is disclosed in writing before treatment, consistently.	✗ Patients learn the cost only when the invoice arrives.
✓ Patients can describe roughly what they were told a service would cost.	✗ Pricing is mentioned verbally once with no written record.
✓ Estimates are honest and close to final costs, with changes explained.	✗ Patients report being surprised by charges never mentioned beforehand.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Pricing is disclosed for the main procedure but not consistently for add-ons.**
Ancillary charges often accumulate without the same disclosure discipline.

2 **A written estimate exists but in language patients find hard to use.**
Technically available and practically useful are different things.

3 **Disclosure happens reliably for scheduled visits but less for same-day walk-ins.**
Time pressure in urgent same-day visits can compress the disclosure step.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent bills against whether pricing was disclosed beforehand.

Week 2 Build a simple written pricing estimate template.

Week 3 Brief reception staff to provide it consistently, including for walk-ins.

Ongoing Spot-check patient recall of pricing periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient what they were told, not what the policy says.
The gap between policy and lived experience is exactly what this checks.

Check same-day walk-in visits specifically.
Disclosure discipline most commonly erodes under time pressure.

E-LEARNING academy.gmj.ge/amb-std2-2-pricing — 30 min · complete before self-assessment

	Standard 2.3 **NON-NEGOTIABLE** · *Standard 2: Reception & Information* **Reception Desk Accessibility**	**ASSESSMENT** ASF-AMB-STD2-v3.0

CR ADAPTED	**TR** FULL	**SM** FULL	**ST** FULL

2.3
NON-NEGOTIABLE
L1

THE STANDARD

Reception Desk Accessibility

At least one reception point is at a height a wheelchair user can approach and communicate with the receptionist at eye level.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is at least one reception point at a height a wheelchair user can comfortably use?** *At least one section genuinely usable, not the whole desk.* Doc: Photo of reception desk height	YES	PARTIAL	NO
2	**Can a wheelchair user communicate with the receptionist at eye level?** *Genuine eye-level interaction, not shouting up over a counter edge.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is the lower section kept clear, not blocked by files or equipment?** *A lower section that's permanently cluttered doesn't meet this in practice.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Desk height check*	Physically checks reception desk height against accessible guidelines.
OBSERVE *Clear access test*	Checks the lower section is genuinely clear and usable.
ASK *Staff awareness interview*	Asks staff whether they're aware of and use the accessible section.

REFERENCES

[7] United Nations. Convention on the Rights of Persons with Disabilities. New York: UN; 2006. Article 9.

Standard 2.3 · *Standard 2: Reception & Information*

Guidance & Learning

GUIDANCE ASF-AMB-STD2-v3.0

WHY THIS STANDARD EXISTS

A standard-height desk forces a wheelchair user to look up at whoever is helping them — an undignified position that's specific, well-observed, and easily fixed once someone actually checks for it.

The evidence: [7] United Nations. Convention on the Rights of Persons with Disabilities. New York: UN; 2006. Article 9.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A wheelchair-height reception point exists and is kept clear.	✗ The entire desk is standard height with no accessible alternative.
✓ A wheelchair user can interact at genuine eye level.	✗ A lower section exists but is covered with files or equipment.
✓ Staff actively use the accessible point without prompting.	✗ Staff are unaware an accessible point exists.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A lower section was built but has become a storage spot for overflow items.**
Good design intentions don't guarantee the space stays usable in daily practice.

2 **The accessible point exists but is positioned away from the main queue.**
Physical accessibility without dignified positioning only partly closes the gap.

3 **New staff aren't briefed on the accessible point during induction.**
Awareness fades from practice if never actively reinforced.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Check current desk height against accessible guidelines.

Week 2 Identify the lowest-cost way to add an accessible section if none exists.

Week 3 Clear and designate the section, briefing all staff.

Ongoing Include the accessible point in routine walk-throughs.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Physically check the height yourself.
A technically accessible but cluttered section doesn't function as intended.

Ask a staff member to demonstrate, not just describe.
Genuine use versus theoretical awareness shows in how confidently they point to it.

E-LEARNING academy.gmj.ge/amb-std2-3-reception-accessibility — 30 min · complete before self-assessment

	Standard 2.4 **CORE** · *Standard 2: Reception & Information* **Health Information Is Genuinely Understandable, Not Just Provided**	**ASSESSMENT** ASF-AMB-STD2-v3.0

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

2.4
CORE
L1

THE STANDARD

Health Information Is Genuinely Understandable, Not Just Provided

Health information given to patients is delivered in plain language and verified as actually understood, not handed over in clinical terminology and assumed to have registered.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is health information routinely delivered in plain language?** *Genuinely accessible language, not clinical terms used without explanation.* Doc: Patient information materials sample	YES	PARTIAL	NO
2	**Is patient understanding actively verified, such as through teach-back?** *An active check, not passive delivery followed by assuming it landed.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are materials available in the languages patients actually need?** *Matched to actual population need.* Doc: Language coverage of materials	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Plain language practice check*	Reviews materials and observes conversations for genuine plain-language use.
OBSERVE *Understanding verification observation*	Observes whether understanding is actively checked, not assumed.
DOCUMENT *Language coverage review*	Reviews materials against the languages patients actually need.

REFERENCES

[8] Health literacy and plain-language communication are established determinants of patient understanding and engagement in care decisions, consistently identified in patient safety literature as distinct from the simple provision of information.

Standard 2.4 · *Standard 2: Reception & Information*

Guidance & Learning

GUIDANCE ASF-AMB-STD2-v3.0

WHY THIS STANDARD EXISTS

Providing information and a patient genuinely understanding it are two different things, and the gap between them is where informed decisions quietly fail to happen.

The evidence: [8] Health literacy and plain-language communication are established determinants of patient understanding and engagement in care decisions, consistently identified in patient safety literature as distinct from the simple provision of information.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Information is consistently delivered in genuine plain language.	✗ Information relies on unexplained clinical terminology.
✓ Patient understanding is actively verified.	✗ Understanding is assumed from a nod.
✓ Materials are available in the languages patients actually need.	✗ Materials exist only in the default language regardless of patient need.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Plain language is used for major decisions but reverts to shorthand for routine information.**
Simplification effort concentrates on high-stakes moments.

2 **Verification happens for complex decisions but not everyday instructions.**
Misunderstood routine instructions still carry real risk.

3 **Materials exist in the majority language but not smaller populations served.**
Coverage matching the majority can leave a meaningful minority unsupported.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current materials and conversation practice for plain-language use.

Week 2 Train staff on teach-back or equivalent techniques.

Week 3 Assess language coverage against actual patient population.

Ongoing Spot-check patient understanding periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient to explain back what they were told.
Tests actual comprehension rather than self-reported confidence.

Check materials for a less common language in the patient population.
Coverage gaps concentrate exactly where they're least visible.

E-LEARNING academy.gmj.ge/amb-std2-4-health-literacy — 30 min · complete before self-assessment

Standard 2.5 **CORE** · *Standard 2: Reception & Information*

Waiting and Queue Time Is Actively Managed

ASSESSMENT ASF-AMB-STD2-v3.0
ISO 9001:2015 §8 Operation

CR ADAPTED	TR FULL	SM FULL	ST FULL

2.5
CORE
L1

THE STANDARD

Waiting and Queue Time Is Actively Managed

Patients waiting for a consultation are managed through a defined queue system with visible, honest wait-time information, not left to wonder how long they'll wait.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Is there a defined queue management system, not an informal first-come approach?** *A specific, functioning system, not assumed self-evident from a waiting room.* Doc: Queue management description	YES	PARTIAL	NO
2	**Is honest wait-time information visible or communicated to waiting patients?** *Genuine, reasonably accurate information, not a vague reassurance.* Doc: Wait-time communication method	YES	PARTIAL	NO
3	**Is there a mechanism to notice if a waiting patient's condition changes?** *Active monitoring, not only queue order.* Doc: Waiting area monitoring process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

OBSERVE *Queue system observation*	Observes the queue system in operation during a busy period.
OBSERVE *Wait-time communication check*	Checks whether wait-time information is genuinely visible and reasonably accurate.
ASK *Waiting area monitoring interview*	Asks staff how they'd notice a waiting patient's condition changing.

REFERENCES

[9] Structured queue management and wait-time transparency are established elements of patient experience and flow-safety frameworks in ambulatory healthcare settings internationally.

Standard 2.5 · *Standard 2: Reception & Information*

Guidance & Learning

GUIDANCE ASF-AMB-STD2-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

An unmanaged queue creates genuine uncertainty and anxiety, particularly for unwell patients, and makes it harder for staff to notice if someone's condition is quietly worsening while waiting.

The evidence: [9] Structured queue management and wait-time transparency are established elements of patient experience and flow-safety frameworks in ambulatory healthcare settings internationally.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A defined queue system operates consistently, even when busy.	✗ No defined system exists beyond who arrived first.
✓ Honest wait-time information is genuinely visible.	✗ No wait-time information is available, or it's routinely inaccurate.
✓ Staff describe an active process for monitoring waiting patients.	✗ No mechanism exists to notice a waiting patient's condition changing.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The queue system works during normal hours but breaks down when busy.**
The system is most needed exactly when under the most strain.

2 **Wait-time information is displayed but not updated as conditions change.**
Stale information can be worse than none.

3 **Monitoring happens informally for obviously unwell patients, not systematically for everyone.**
Deterioration can be subtle and easy to miss without a systematic check.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current queue practice during a known busy period.

Week 2 Establish a defined system with visible wait-time communication.

Week 3 Build a periodic waiting-area check into staff routine.

Ongoing Review wait-time accuracy periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe during a genuinely busy period.
Systems that work fine when quiet often reveal gaps under pressure.

Ask how long since the waiting area was last checked for condition changes.
A specific answer reveals genuine practice versus a theoretical process.

E-LEARNING academy.gmj.ge/amb-std2-5-queue-management — 30 min · complete before self-assessment

STANDARD 3

Environment & Shared Spaces

MANDATORY

6 criteria

Standard 3.1 **NON-NEGOTIABLE** · *Standard 3: Environment & Shared Spaces*

Water Supply Is Safe and Monitored

ASSESSMENT ASF-AMB-STD3-v3.0
ISO 9001:2015 §8 Operation

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.1
NON-NEGOTIABLE
L1

THE STANDARD

Water Supply Is Safe and Monitored

Water quality is tested on a defined schedule and a contingency plan exists for interruption — not an assumption that municipal supply is automatically safe.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is water quality tested on a defined, regular schedule, with records kept?** *An assumption is not a verified fact.* Doc: Water testing records	YES	PARTIAL	NO
2	**Is there a documented contingency plan for water supply interruption?** *A plan written during an actual interruption is not a contingency plan.* Doc: Contingency plan document	YES	PARTIAL	NO
3	**Are test results reviewed and acted on, not just filed?** *A concerning result nobody reads is no better than not testing.* Doc: Review and action record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Testing record review*	Reviews water testing records for consistency and whether the schedule is followed.
DOCUMENT *Contingency plan check*	Reviews the plan for a real, specific backup arrangement.
ASK *Response protocol interview*	Asks staff what actually happens if a test result is concerning.

REFERENCES

[10] World Health Organization, UNICEF. Water, sanitation and hygiene in health care facilities: practical steps to achieve universal access to quality care. Geneva: WHO; 2019.

Standard 3.1 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE ASF-AMB-STD3-v3.0
ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

Water quality failures can silently undermine every other infection-control measure in the clinic. Testing and a contingency plan turn an assumption into a verified fact.

The evidence: [10] World Health Organization, UNICEF. Water, sanitation and hygiene in health care facilities: practical steps to achieve universal access to quality care. Geneva: WHO; 2019.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Testing happens on a defined schedule with consistent records.	✗ No regular testing beyond an assumption of municipal safety.
✓ A specific, actionable contingency plan exists.	✗ No contingency plan exists.
✓ Concerning results trigger a known, followed response process.	✗ Results, when they exist, are filed without review.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Testing happens but with gaps during busy periods.**
Routine tasks without strong enforcement are often the first thing skipped.

2 **A contingency plan exists but has never been reviewed since written.**
An untested plan may not reflect current capacity.

3 **Results are reviewed informally with no documented follow-up.**
Informal review depends entirely on who happens to be paying attention.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current testing frequency for gaps.

Week 2 Establish a specific contingency plan for interruption.

Week 3 Define a clear response process for concerning results.

Ongoing Review testing consistency on a fixed schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for actual test records, not a general assurance.
Dated records are the only real evidence of a consistent schedule.

Ask what happened the last time a result was concerning.
A real example reveals more than a policy description.

E-LEARNING academy.gmj.ge/amb-std3-1-water-safety — 30 min · complete before self-assessment

	Standard 3.2 **NON-NEGOTIABLE** · *Standard 3: Environment & Shared Spaces* **Medical Equipment Is Maintained on Schedule**	**ASSESSMENT** ASF-AMB-STD3-v3.0 ISO 9001:2015 §7 Support

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.2
NON-NEGOTIABLE
L1

THE STANDARD

Medical Equipment Is Maintained on Schedule

A maintenance programme covers all clinical equipment on a defined schedule, and faulty equipment is genuinely removed from use, not kept in service pending eventual repair.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a documented maintenance schedule covering all clinical equipment?** *A defined, proactive schedule, not reactive maintenance.* Doc: Maintenance schedule and log	YES	PARTIAL	NO
2	**Is faulty equipment actually removed from use, not kept accessible awaiting repair?** *A tag alone isn't sufficient if the equipment remains physically accessible.* Doc: Removal-from-service record	YES	PARTIAL	NO
3	**Is there a named person responsible for the maintenance programme?** *Diffuse responsibility usually means inconsistency.* Doc: Role assignment record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Maintenance schedule review*	Reviews the schedule and log for completeness and consistency.
OBSERVE *Faulty equipment check*	Checks whether flagged equipment remains physically accessible.
ASK *Responsible person interview*	Asks whoever is responsible to describe the actual process.

REFERENCES

[11] Biomedical equipment maintenance frameworks consistently identify scheduled preventive maintenance, combined with clear removal-from-service protocols, as the primary control against equipment-related patient harm.

Standard 3.2 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE ASF-AMB-STD3-v3.0
ISO 9001:2015 §7 Support

WHY THIS STANDARD EXISTS

Equipment that silently drifts out of calibration is often more dangerous than equipment that visibly fails, precisely because nothing signals the problem until it affects a patient.

The evidence: [11] Biomedical equipment maintenance frameworks consistently identify scheduled preventive maintenance, combined with clear removal-from-service protocols, as the primary control against equipment-related patient harm.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A comprehensive schedule is consistently followed.	✗ Maintenance happens reactively, only after failure.
✓ Faulty equipment is physically removed from use immediately.	✗ Faulty equipment remains available and sometimes used.
✓ A named person owns the programme confidently.	✗ Nobody can identify who is responsible.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A schedule exists for major equipment but not smaller items.**
Coverage often reflects value or visibility rather than actual risk.

2 **Faulty equipment is tagged but not physically relocated.**
A tag depends on every staff member noticing it every time.

3 **Responsibility sits with someone who has since changed roles informally.**
Ownership gaps often follow staff transitions.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit equipment against the maintenance schedule for gaps.

Week 2 Establish a process for physically removing faulty equipment.

Week 3 Name a specific owner of the programme.

Ongoing Review maintenance log currency against the schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Look for equipment that should be flagged but isn't.
The absence of any flagged equipment is itself worth questioning.

Check whether tagged equipment is still physically reachable.
A tag alone doesn't prevent use if it sits in its normal location.

E-LEARNING academy.gmj.ge/amb-std3-2-equipment-maintenance — 30 min · complete before self-assessment

Standard 3.3 **CORE** · *Standard 3: Environment & Shared Spaces*

Shared Spaces Are Genuinely Clean

ASSESSMENT ASF-AMB-STD3-v3.0
ISO 9001:2015 §8 Operation

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.3
CORE
L1

THE STANDARD

Shared Spaces Are Genuinely Clean

Shared clinical and waiting areas are cleaned on a documented schedule, with cleanliness verified by more than a visual check on the day of assessment.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a documented cleaning schedule with records kept?** *A specific, dated schedule, not a general statement.* Doc: Cleaning schedule and log	YES	PARTIAL	NO
2	**Is cleaning verified through more than a visual check?** *Visual cleanliness and actual microbial cleanliness aren't the same thing.* Doc: Verification or audit record	YES	PARTIAL	NO
3	**Are high-touch surfaces specifically included?** *Door handles and switches are easy to overlook relative to visible surfaces.* Doc: High-touch surface schedule	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Cleaning schedule review*	Reviews the schedule against completion records.
OBSERVE *High-touch surface check*	Checks whether high-touch surfaces are specifically addressed.
ASK *Verification process interview*	Asks staff how cleanliness is actually verified.

REFERENCES

[12] Environmental cleanliness in shared healthcare spaces is a recognised contributing factor to healthcare-associated infection transmission risk, distinct from direct clinical contact precautions.

Standard 3.3 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE ASF-AMB-STD3-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

A space that looks clean on the day of an inspection and a space that is reliably clean are not always the same thing.

The evidence: [12] Environmental cleanliness in shared healthcare spaces is a recognised contributing factor to healthcare-associated infection transmission risk, distinct from direct clinical contact precautions.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A documented, consistently followed schedule covers all shared spaces.	✗ No documented schedule beyond good intentions.
✓ High-touch surfaces are specifically addressed.	✗ High-touch surfaces show visible neglect.
✓ Cleanliness is verified through a defined process.	✗ Verification is undocumented and inconsistent.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A schedule exists for the waiting room but not less-visited areas.**
Peripheral areas often receive less consistent attention.

2 **Cleaning happens but high-touch surfaces aren't specifically called out.**
A general routine can miss the surfaces that matter most.

3 **Verification exists informally with no documentation.**
An informal check depends entirely on who happens to be paying attention.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current schedules for coverage gaps.

Week 2 Add specific high-touch surface cleaning to the schedule.

Week 3 Establish a simple verification step.

Ongoing Audit cleaning log completeness periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check high-touch surfaces specifically.
Door handles and switches reveal more than open floor areas.

Ask for the log, not a general assurance.
Dated records are the only real evidence.

E-LEARNING academy.gmj.ge/amb-std3-3-cleanliness — 30 min · complete before self-assessment

Standard 3.4 **NON-NEGOTIABLE** · *Standard 3: Environment & Shared Spaces*

Facility Risks Are Tracked in One Integrated Register

ASSESSMENT ASF-AMB-STD3-v3.0
ISO 9001:2015 §6 Planning

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

3.4
NON-NEGOTIABLE
L1

THE STANDARD

Facility Risks Are Tracked in One Integrated Register

Water safety, fire safety, and equipment maintenance data feed into one integrated risk register, not separate untracked lists.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Do water safety, fire safety, and equipment data feed into one register?** *A single place to see the whole risk picture, not scattered logs.* Doc: Integrated risk register document	YES	PARTIAL	NO
2	**Is the register reviewed on a defined schedule by clinic leadership?** *Review at a level that can act across domains.* Doc: Review meeting record	YES	PARTIAL	NO
3	**Does the register prioritise risks, not just list them?** *A genuine tool ranks what needs attention first.* Doc: Risk prioritisation criteria	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Register completeness review*	Reviews integration across safety domains.
DOCUMENT *Review schedule check*	Checks for evidence of defined-schedule review.
ASK *Prioritisation interview*	Asks how risks are prioritised, not just logged.

REFERENCES

[13] Integrated environment-of-care risk management, tying individual facility safety domains into one reviewed register, is an established approach in international facility safety frameworks.

Standard 3.4 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE ASF-AMB-STD3-v3.0
ISO 9001:2015 §6 Planning

WHY THIS STANDARD EXISTS

Individual safety checks can each look fine in isolation while the overall risk picture goes unexamined. An integrated register lets leadership see the whole picture at once.

The evidence: [13] Integrated environment-of-care risk management, tying individual facility safety domains into one reviewed register, is an established approach in international facility safety frameworks.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Facility risks feed into one integrated register.	✗ Records exist as entirely separate, unconnected logs.
✓ The register is reviewed on a defined schedule.	✗ No defined review schedule exists.
✓ Risks are prioritised, with highest-risk items addressed first.	✗ All items are treated with equal, undifferentiated priority.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Individual domain tracking is strong but nothing integrates them.**
Good individual records don't automatically produce a combined view.

2 **A register exists but review happens irregularly.**
An ad hoc pattern risks the register becoming stale.

3 **The register lists risks without ranking them.**
A list without prioritisation provides less real value.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Inventory current safety tracking across domains.

Week 2 Consolidate into one integrated register.

Week 3 Establish a defined review schedule.

Ongoing Review and reprioritise on schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the register itself, not descriptions of individual tracking.
Integration itself is what this checks.

Ask who reviews it and how often, specifically.
A specific process is the real evidence of active use.

E-LEARNING academy.gmj.ge/amb-std3-4-risk-register — 30 min · complete before self-assessment

Standard 3.5 **CORE** · *Standard 3: Environment & Shared Spaces*

Diagnostic Equipment On-Site Is Calibrated, Not Just Maintained

ASSESSMENT ASF-AMB-STD3-v3.0

ISO 9001:2015 §7 Support

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.5
CORE
L1

THE STANDARD

Diagnostic Equipment On-Site Is Calibrated, Not Just Maintained

Any diagnostic equipment on-site — X-ray, ultrasound, ECG — is calibrated against a defined schedule, verified for accuracy, not just confirmed to be running.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Is diagnostic equipment calibrated against a defined schedule, not just confirmed to be running?** *Calibration verifies accuracy; maintenance only verifies function.* Doc: Calibration schedule and log	YES	PARTIAL	NO
2	**Is calibration performed or verified by a qualified, external or certified source?** *Self-assessed calibration by untrained staff doesn't meet this.* Doc: Calibration certificate	YES	PARTIAL	NO
3	**Is equipment found out of calibration removed from use until corrected?** *Continuing to use miscalibrated equipment defeats the purpose of checking at all.* Doc: Removal-from-service record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Calibration record review*	Reviews calibration certificates and schedule adherence.
DOCUMENT *Qualified source check*	Confirms calibration is performed by a qualified, certified source.
OBSERVE *Out-of-calibration handling check*	Checks whether equipment found miscalibrated is genuinely removed from use.

REFERENCES

[14] Calibration verification, distinct from general equipment maintenance, is an established requirement in diagnostic equipment quality frameworks specifically because functional equipment can still produce inaccurate output.

Standard 3.5 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE ASF-AMB-STD3-v3.0
ISO 9001:2015 §7 Support

WHY THIS STANDARD EXISTS

Equipment that runs perfectly can still output an incorrect value if never calibrated — an X-ray machine can deliver the wrong radiation dose, an ECG can misreport a rhythm, while appearing to function normally the entire time.

The evidence: [14] Calibration verification, distinct from general equipment maintenance, is an established requirement in diagnostic equipment quality frameworks specifically because functional equipment can still produce inaccurate output.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Equipment is calibrated on a defined schedule by a qualified source.	✗ No calibration schedule exists beyond general maintenance.
✓ Calibration certificates are current and retained.	✗ Calibration, if claimed, has no verifiable certificate.
✓ Miscalibrated equipment is genuinely removed from use until corrected.	✗ Equipment continues in use despite known calibration issues.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Calibration happens for the primary diagnostic device but not secondary equipment.**
Attention often concentrates on the most visible or expensive equipment.

2 **Calibration certificates exist but are past their valid period.**
An expired certificate provides no current assurance.

3 **Miscalibration is noted but correction is delayed without removing the equipment from use.**
A delay in correction with continued use still exposes patients to inaccurate results.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Inventory all diagnostic equipment and current calibration status.

Week 2 Schedule calibration with a qualified source for any equipment overdue.

Week 3 Establish a removal-from-service rule for miscalibrated equipment.

Ongoing Track calibration certificate expiry proactively.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the calibration certificate itself, not a statement that equipment works.
A certificate from a qualified source is the only real evidence of genuine calibration.

Check certificate dates against the actual current date.
An expired certificate is a common, specific gap worth checking directly.

E-LEARNING academy.gmj.ge/amb-std3-5-calibration — 30 min · complete before self-assessment

Standard 3.6 **NON-NEGOTIABLE** · *Standard 3: Environment & Shared Spaces*

Point-of-Care Testing Has Real Quality Control, Not Just a Working Device

ASSESSMENT ASF-AMB-STD3-v3.0
ISO 9001:2015 §8 Operation

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.6
NON-NEGOTIABLE
L1

THE STANDARD

Point-of-Care Testing Has Real Quality Control, Not Just a Working Device

Any point-of-care test performed on-site — rapid strep, glucose, pregnancy, or similar — is run against a documented quality control process, not assumed accurate because the device powers on.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is a documented quality control process run for each point-of-care test type, not just assumed from the device working?** *A specific control sample check, not confirmation the device turns on.* Doc: Quality control log	YES	PARTIAL	NO
2	**Are staff performing point-of-care tests specifically trained and assessed as competent?** *Training specific to the test, not general clinical competence.* Doc: Staff training and competency record	YES	PARTIAL	NO
3	**Are quality control failures acted on before patient results are reported?** *A failed control that doesn't stop patient testing provides no real protection.* Doc: Quality control failure response record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Quality control log review*	Reviews the quality control log for consistency and completeness per test type.
DOCUMENT *Staff competency review*	Reviews training and competency assessment records for staff performing point-of-care testing.
ASK *Failure response interview*	Asks staff what happens when a quality control check fails.

REFERENCES

[15] International Organization for Standardization. ISO 15189:2022 — Medical laboratories: requirements for quality and competence. Geneva: ISO; 2022 — establishes quality control requirements specifically applicable to point-of-care testing, distinct from centralised laboratory testing.

Standard 3.6 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE ASF-AMB-STD3-v3.0
ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

Point-of-care devices are operated by staff who are often not laboratory-trained, in a decentralised setting without a laboratory's usual oversight — a device that appears to work can still give a false result without a specific quality-control process to catch it.

The evidence: [15] International Organization for Standardization. ISO 15189:2022 — Medical laboratories: requirements for quality and competence. Geneva: ISO; 2022 — establishes quality control requirements specifically applicable to point-of-care testing, distinct from centralised laboratory testing.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A documented quality control process runs consistently for every point-of-care test type.	✗ No quality control process exists beyond the device appearing to work.
✓ Staff are specifically trained and assessed as competent for the tests they perform.	✗ Staff perform tests with no specific training or competency assessment.
✓ A quality control failure stops patient testing until resolved.	✗ Quality control failures, if noticed, don't stop patient testing.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Quality control is run for the most frequently used test but not less common ones.**
Attention concentrates on high-volume tests, leaving others under-checked.

2 **Staff were trained once at introduction but never reassessed.**
Competency can drift without periodic reassessment.

3 **A failed control is documented but patient testing continues regardless.**
Documentation without stopping testing provides no real protection.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Inventory all point-of-care tests performed and current quality control practice.

Week 2 Establish a documented quality control process for every test type.

Week 3 Train and formally assess staff competency for each test performed.

Ongoing Audit quality control log completeness periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual quality control log, not a description of the testing process.
Dated records are the only real evidence of a consistent process.

Ask what happens specifically when a control fails.
A real, specific answer reveals whether this is genuine practice or assumed.

E-LEARNING academy.gmj.ge/amb-std3-6-poct-quality — 30 min · complete before self-assessment

STANDARD 4

Care & Treatment

MANDATORY

12 criteria

	Standard 4.1 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **Consent Is Real, Not a Signature**	ASSESSMENT ASF-AMB-STD4-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

4.1
NON-NEGOTIABLE
L1

THE STANDARD

Consent Is Real, Not a Signature

Before any procedure, the patient has a genuine conversation about what will happen, why, and what the alternatives are, and can explain it back in their own words — not a form signed without real understanding.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does a genuine conversation happen before the procedure, not just a form handed over?** *An actual explanation, not a document presented for signature.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Can the patient explain back, in their own words, what will happen and why?** *Tests genuine understanding, not just that a conversation occurred.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are alternatives and the option to decline genuinely discussed?** *Consent that only presents one path isn't genuinely informed.* Doc: Consent documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Consent conversation observation*	Observes an actual consent conversation for genuine explanation, not form presentation.
ASK *Patient understanding check*	Asks a patient to explain back what they understood about their procedure.
DOCUMENT *Alternatives documentation review*	Reviews whether alternatives and the right to decline are documented as discussed.

REFERENCES

[16] World Health Organization. WHO guidelines for safe surgery 2009: safe surgery saves lives. Geneva: WHO; 2009.

Standard 4.1 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

WHY THIS STANDARD EXISTS

A signature on a consent form proves a document was signed, not that the patient understood what they agreed to. Genuine consent requires genuine understanding, verified, not assumed from a signature.

The evidence: [16] World Health Organization. WHO guidelines for safe surgery 2009: safe surgery saves lives. Geneva: WHO; 2009.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine conversation happens before every procedure.	✗ A form is presented for signature with no real conversation.
✓ Patients can explain back what will happen and why.	✗ Patients cannot explain what they agreed to.
✓ Alternatives and the right to decline are genuinely discussed.	✗ Only one path is presented, with no genuine alternative discussed.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Conversation happens for major procedures but is rushed for routine ones.**
Routine-seeming procedures still deserve genuine understanding.

2 **Understanding is assumed from the patient nodding along.**
A nod doesn't confirm genuine comprehension.

3 **Alternatives are mentioned but not genuinely explored.**
A passing mention isn't the same as a real discussion.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current consent practice for genuine conversation versus form presentation.

Week 2 Train staff on teach-back verification for consent specifically.

Week 3 Build alternatives discussion into the standard consent process.

Ongoing Spot-check patient understanding after consent conversations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the patient, not the clinician, to explain the procedure.
This tests actual understanding, not staff confidence in their own explanation.

Check for rushed consent on routine procedures specifically.
This is where genuine practice most commonly erodes.

E-LEARNING academy.gmj.ge/amb-std4-1-consent — 30 min · complete before self-assessment

Standard 4.2 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Staff Credentials Are Checked and Current

ASSESSMENT ASF-AMB-STD4-v3.0
ISO 9001:2015 §7 Support

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.2
NON-NEGOTIABLE
L1

THE STANDARD

Staff Credentials Are Checked and Current

Every clinical staff member's licence and credentials are verified directly with the issuing body and kept current, not accepted on the staff member's own word.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Is every clinical staff credential verified directly with the issuing body, not just filed on presentation?** *Direct verification, not trust in a presented document alone.* Doc: Verification record	YES	PARTIAL	NO
2	**Is credential currency rechecked periodically, not only at hiring?** *A licence can lapse after hiring without anyone noticing.* Doc: Periodic recheck schedule	YES	PARTIAL	NO
3	**Is there a defined process if a credential is found lapsed or invalid?** *Discovery without a defined response provides no real protection.* Doc: Response protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Verification record review*	Reviews evidence credentials were verified directly with the issuing body.
DOCUMENT *Recheck schedule review*	Reviews whether currency is rechecked periodically, not only at hiring.
ASK *Response protocol interview*	Asks what happens if a credential is found lapsed.

REFERENCES

[17] Credential verification failures are a recurring, preventable category in patient safety literature — the checkable fact is whether verification happened directly with the issuing body, not whether a certificate was filed.

Standard 4.2 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0
ISO 9001:2015 §7 Support

WHY THIS STANDARD EXISTS

A lapsed or fraudulent credential discovered only after harm occurs is a preventable failure — verification with the actual issuing body, not just checking a certificate exists, is what catches this before it matters.

The evidence: [17] Credential verification failures are a recurring, preventable category in patient safety literature — the checkable fact is whether verification happened directly with the issuing body, not whether a certificate was filed.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every credential is verified directly with the issuing body.	✗ Credentials are accepted on presentation without direct verification.
✓ Currency is rechecked on a defined periodic schedule.	✗ No periodic recheck happens after hiring.
✓ A clear response protocol exists for a lapsed credential.	✗ No defined process exists if a lapse is discovered.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Verification happens at hiring but is never repeated.**
A credential valid at hiring can lapse years into employment.

2 **Verification happens for physicians but less consistently for other clinical staff.**
Coverage often concentrates on the most visible role.

3 **A response protocol exists but has never actually been used or tested.**
An untested protocol may not translate smoothly into real action.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit current credential verification practice for all clinical staff.

Week 2 Establish direct verification with issuing bodies where not already done.

Week 3 Set a periodic recheck schedule.

Ongoing Review credential currency on the defined schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how verification was done for a specific staff member, by name.
A specific example reveals whether this is genuine practice.

Ask about non-physician clinical staff specifically.
Coverage often concentrates on physicians, leaving other roles less verified.

E-LEARNING academy.gmj.ge/amb-std4-2-credentials — 30 min · complete before self-assessment

	Standard 4.3 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **Hand Hygiene Actually Happens**	ASSESSMENT ASF-AMB-STD4-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

4.3
NON-NEGOTIABLE
L1

THE STANDARD

Hand Hygiene Actually Happens

Hand hygiene is performed at the correct moments, verified through direct observation, not assumed from the presence of sinks or sanitiser dispensers.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is hand hygiene performed before and after every patient contact, not just when convenient?** *Every contact, not a general habit applied inconsistently.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Are sanitiser or handwashing stations genuinely accessible at the point of care?** *Accessible at the moment needed, not down the hall.* Doc: Photo of station placement	YES	PARTIAL	NO
3	**Is hand hygiene compliance directly observed periodically, not assumed?** *Direct observation, not reliance on self-report.* Doc: Observation audit record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Direct hand hygiene observation*	Observes actual hand hygiene practice during patient contacts.
OBSERVE *Station accessibility check*	Checks that stations are genuinely accessible at the point of care.
DOCUMENT *Compliance audit review*	Reviews periodic compliance audit records.

REFERENCES

[18] World Health Organization. WHO guidelines on hand hygiene in health care. Geneva: WHO; 2009.

Standard 4.3 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

WHY THIS STANDARD EXISTS

Hand hygiene compliance is one of the most well-established, evidence-based infection prevention practices, and its value depends entirely on it actually happening at the right moments, not on hand hygiene facilities simply being present.

The evidence: [18] World Health Organization. WHO guidelines on hand hygiene in health care. Geneva: WHO; 2009.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Hand hygiene is consistently performed at the correct moments.	✗ Hand hygiene is inconsistent or skipped under time pressure.
✓ Stations are genuinely accessible at the point of care.	✗ Stations exist but are inconveniently placed.
✓ Compliance is directly observed and audited periodically.	✗ Compliance is assumed, never actually observed.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Compliance is strong for obvious contacts but weaker for brief interactions.**
Perceived low-risk contacts often receive less consistent attention.

2 **Stations exist but are sometimes out of supply.**
An empty dispenser provides no real protection.

3 **Audits happen but only during announced observation periods.**
Behaviour during known observation may not reflect routine practice.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Conduct an unannounced observation of current hand hygiene practice.

Week 2 Address any station accessibility or supply gaps found.

Week 3 Establish a periodic, partly unannounced audit schedule.

Ongoing Track compliance trends and address any decline.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe unannounced, not during a scheduled audit.
Announced observation can produce artificially high compliance.

Check dispenser supply levels directly.
An empty dispenser is a common, easily missed gap.

E-LEARNING academy.gmj.ge/amb-std4-3-hand-hygiene — 30 min · complete before self-assessment

Standard 4.4 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Every Patient Gets a Real Assessment

ASSESSMENT ASF-AMB-STD4-v3.0
ISO 9001:2015 §8 Operation

CR FULL	TR FULL	SM FULL	ST FULL

4.4
NON-NEGOTIABLE
L1

THE STANDARD

Every Patient Gets a Real Assessment

Every patient receives a genuine clinical assessment appropriate to their presenting concern, documented specifically, not a generic note applied regardless of the actual visit.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Is the assessment specific to this patient's actual presenting concern, not a generic template?** *Genuinely reflects what was found, not a copied general note.* Doc: Assessment record sample	YES	PARTIAL	NO
2	**Is the assessment documented at the time of the visit, not reconstructed later?** *Contemporaneous documentation is more reliable than reconstruction.* Doc: Documentation timestamp	YES	PARTIAL	NO
3	**Would another clinician reading this assessment understand what was actually found?** *Tests genuine usefulness to a future reader, not just completion.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Assessment specificity review*	Reviews a sample of assessments for genuine, patient-specific content.
DOCUMENT *Timing review*	Checks documentation timestamps against actual visit time.
ASK *Clinician readability interview*	Asks a different clinician to review a sample assessment and describe what it tells them.

REFERENCES

[19] Individualised, documented care assessment is consistently associated with improved continuity of care across providers in health services literature, distinct from assessment quality alone.

Standard 4.4 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

A documented assessment that doesn't reflect what was actually found provides no real basis for the care decisions that follow, and can mislead any future clinician who relies on it.

The evidence: [19] Individualised, documented care assessment is consistently associated with improved continuity of care across providers in health services literature, distinct from assessment quality alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Assessments are specific to each patient's actual presentation.	✗ Assessments read as generic templates regardless of the actual visit.
✓ Documentation happens at the time of the visit.	✗ Documentation is reconstructed well after the visit.
✓ A different clinician can understand what was found from the record.	✗ A different clinician cannot tell what was actually found.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Assessments are specific for complex presentations but generic for routine ones.**
Perceived complexity often determines documentation effort.

2 **Documentation happens same-day but not at the actual time of assessment.**
Even same-day reconstruction can lose accuracy.

3 **Assessments are specific but use abbreviations unclear to other staff.**
Specificity that isn't genuinely readable to others provides limited real value.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of recent assessments for genuine specificity.

Week 2 Reinforce contemporaneous documentation practice.

Week 3 Standardise abbreviation use for cross-staff readability.

Ongoing Periodically review assessment quality across different clinicians.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Compare two assessments from the same clinician for different patients.
Genuinely different content reveals real specificity; near-identical text reveals a template.

Ask a different staff member to interpret a sample record.
Tests real readability, not just the original author's understanding.

E-LEARNING academy.gmj.ge/amb-std4-4-real-assessment — 30 min · complete before self-assessment

Standard 4.5 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Medication Prescribing Is Safe

ASSESSMENT ASF-AMB-STD4-v3.0
ISO 9001:2015 §8 Operation

CR FULL	TR ADAPTED	SM FULL	ST FULL

4.5
NON-NEGOTIABLE
L1

THE STANDARD

Medication Prescribing Is Safe

Prescriptions are checked, legible, and follow a defined safety process — including a genuine second check for high-risk medications by a trained, designated person, whoever that is at this facility.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are prescriptions legible and complete, with dose, route, and frequency unambiguous?** *Illegibility itself is a preventable safety risk.* Doc: Prescription sample	YES	PARTIAL	NO
2	**Is there a genuine second check for high-risk medications by a trained, designated person?** *Independent, not the same person confirming their own work.* Doc: Second-check record	YES	PARTIAL	NO
3	**Who performs the second check, and are they specifically trained for it?** *A named role, trained for the function, not whoever happens to be available.* Doc: Role and training record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Prescription legibility review*	Reviews a sample of prescriptions for legibility and completeness.
DOCUMENT *Second-check record review*	Reviews evidence of a genuine, independent second check for high-risk medications.
ASK *Second-check role interview*	Asks who performs the second check and confirms specific training for the role.

REFERENCES

[20] World Health Organization. Medication without harm: WHO global patient safety challenge. Geneva: WHO; 2017.

Standard 4.5 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

Prescribing errors are among the most common preventable causes of patient harm, and the second-check function can be performed reliably by any trained, designated person — a pharmacist, a second physician, or a senior nurse — not only a clinical pharmacist role many ambulatory clinics don't have.

The evidence: [20] World Health Organization. Medication without harm: WHO global patient safety challenge. Geneva: WHO; 2017.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Prescriptions are consistently legible and complete.	✗ Prescriptions are frequently illegible or ambiguous.
✓ A genuine, independent second check happens for high-risk medications.	✗ No independent second check exists for high-risk medications.
✓ The second-check role is named and specifically trained, whoever holds it.	✗ No one is specifically trained for the second-check function.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Second checks happen for the most obviously high-risk medications but not a complete list.**
A narrower list than the facility's actual high-risk medications leaves real gaps.

2 **The second check exists but isn't genuinely independent — same effective judgement twice.**
Independent verification requires a second person forming their own judgement.

3 **Legibility is good for handwritten scripts but electronic entries have unclear abbreviations.**
Illegibility can take digital forms too, not only handwriting.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of prescriptions for legibility and second-check evidence.

Week 2 Define the facility's specific high-risk medication list.

Week 3 Name and train a specific person or role for the second-check function.

Ongoing Audit second-check genuineness periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask who performs the second check, by name and role.
A facility without a clinical pharmacist can still meet this fully if the function is genuinely owned by someone else.

Check for genuine independence, not sequential confirmation by the same judgement.
A real second check reveals itself in a specific, separate example.

E-LEARNING academy.gmj.ge/amb-std4-5-prescribing — 30 min · complete before self-assessment

	Standard 4.6 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Patient Identified Correctly at Every Point of Contact**	**ASSESSMENT** ASF-AMB-STD4-v3.0 ISO 9001:2015 §8 Operation

CR FULL	TR FULL	SM FULL	ST FULL

4.6
NON-NEGOTIABLE
L1

THE STANDARD

Patient Identified Correctly at Every Point of Contact

Every patient is verified using at least two identifiers before any medication, procedure, or specimen collection — applied consistently, not concentrated in one department.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are two identifiers checked before every medication, procedure, and specimen collection?** *Applied consistently across every point of contact, not just one.* Doc: Identification protocol	YES	PARTIAL	NO
2	**Is a room or appointment slot number ever used as an identifier?** *These change and are never acceptable as an identifier alone.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is identification checked independently at each new point of contact?** *Not relying on identification done earlier in the same visit.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Identification practice observation*	Observes identification practice at multiple points of contact during a visit.
ASK *Staff practice interview*	Asks staff what counts as an acceptable identifier.
DOCUMENT *Cross-point consistency review*	Reviews identification practice across different service points for consistency.

REFERENCES

[21] Joint Commission International. International patient safety goals. 7th ed. Oak Brook (IL): JCI; 2020.

Standard 4.6 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

A misidentified patient at any point of contact can result in the wrong medication, procedure, or specimen being attributed to the wrong person — this has to be a universal habit, not a rule that lives in only one part of the clinic's workflow.

The evidence: [21] Joint Commission International. International patient safety goals. 7th ed. Oak Brook (IL): JCI; 2020.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Two identifiers are checked before every medication, procedure, and specimen collection.	✗ Two-identifier checking happens in one department but not consistently elsewhere.
✓ Staff clearly state room or slot numbers are never acceptable alone.	✗ Room or slot numbers are used as a de facto identifier.
✓ Identification is consistent across every point of contact.	✗ Identification is treated as a one-time check for the whole visit.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The practice is strong where introduced first but hasn't spread clinic-wide.**
A safety practice introduced for one purpose sometimes doesn't generalise without deliberate effort.

2 **Staff verify identity but use a mix of acceptable and unacceptable identifiers.**
Partial adherence can be harder to catch than complete absence.

3 **Verification happens at check-in and is assumed to carry through the visit.**
A single check doesn't protect against a mix-up during a later step.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit identification practice across all points of contact.

Week 2 Brief all staff that room or slot numbers are never acceptable alone.

Week 3 Extend consistent identification practice clinic-wide.

Ongoing Spot-check identification practice across different service points.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe a full visit sequence, not just one department.
This is where the practice most commonly fails to generalise.

Ask specifically whether room or slot numbers are ever used.
A direct question often reveals what a general policy question won't.

E-LEARNING academy.gmj.ge/amb-std4-6-patient-id — 30 min · complete before self-assessment

Standard 4.7 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

A Defined, Working Referral Relationship With a Named Receiving Facility

ASSESSMENT ASF-AMB-STD4-v3.0
ISO 9001:2015 §8 Operation

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.7
NON-NEGOTIABLE
L1

THE STANDARD

A Defined, Working Referral Relationship With a Named Receiving Facility

The clinic has a specific, working relationship with a named facility able to receive patients needing care beyond this clinic's own capacity — not a general assumption that somewhere will take the patient if needed.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific, named receiving facility for cases beyond this clinic's capacity?** *A specific name and working relationship, not a general assumption.* Doc: Referral agreement or relationship record	YES	PARTIAL	NO
2	**Has this relationship been used and does it actually work in practice?** *A theoretical relationship and a genuinely functioning one are different things.* Doc: Recent referral example	YES	PARTIAL	NO
3	**Do staff know the specific process for making this referral, without hesitation?** *Genuine, immediate familiarity, not something staff have to figure out under pressure.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Referral relationship review*	Reviews evidence of a specific, named receiving facility relationship.
DOCUMENT *Recent use review*	Reviews a recent example of the referral relationship actually being used.
ASK *Staff process interview*	Asks staff to describe the referral process without hesitation.

REFERENCES

[22] Continuity of care across facility transitions is identified in cross-border and ambulatory healthcare literature as a distinct risk point, with informal or undefined referral relationships directly linked to preventable delays in care.

Standard 4.7 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

An ambulatory clinic is frequently not the top of the care chain, and a patient needing more than this clinic can offer depends on a referral relationship that actually works, not one that exists only in theory.

The evidence: [22] Continuity of care across facility transitions is identified in cross-border and ambulatory healthcare literature as a distinct risk point, with informal or undefined referral relationships directly linked to preventable delays in care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, named receiving facility relationship exists and is genuinely used.	✗ No specific facility is named; referral is a general assumption.
✓ A recent, real example demonstrates the relationship works in practice.	✗ The relationship exists on paper but has never actually been used.
✓ Staff describe the referral process immediately and confidently.	✗ Staff are uncertain about the referral process.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A relationship exists for the most common referral need but not less frequent ones.**
Coverage often concentrates on the most visible need.

2 **The relationship worked once, historically, but hasn't been confirmed as still active.**
Relationships can lapse without anyone at either end noticing.

3 **Staff know the process exists but not the specific steps.**
General awareness and operational readiness are different things.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Identify the most likely referral needs beyond this clinic's capacity.

Week 2 Establish or confirm a specific, named receiving facility relationship for each.

Week 3 Brief all staff on the specific referral process.

Ongoing Confirm the relationship remains active periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent referral example, not a description of the relationship.
A real example reveals whether this genuinely functions.

Ask a staff member to describe the process without prompting.
Immediate, confident recall reveals genuine operational readiness.

E-LEARNING academy.gmj.ge/amb-std4-7-referral-relationship — 30 min · complete before self-assessment

Standard 4.8 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Referral Follow-Through Is Confirmed, Not Assumed

ASSESSMENT ASF-AMB-STD4-v3.0
ISO 9001:2015 §8 Operation

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.8
NON-NEGOTIABLE
L1

THE STANDARD

Referral Follow-Through Is Confirmed, Not Assumed

When a patient is referred elsewhere, the clinic confirms the patient actually reached and was seen by the receiving facility — not assumed from the referral having been made.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Is there a specific process to confirm a referred patient actually reached the receiving facility?** *Active confirmation, not an assumption the referral was completed.* Doc: Referral follow-through record	YES	PARTIAL	NO
2	**Is there a defined action if a patient does not confirm as having reached the referral?** *Detecting a gap without acting on it provides no real protection.* Doc: Non-completion response protocol	YES	PARTIAL	NO
3	**Is follow-through tracked as a specific, reviewed metric?** *Untracked follow-through cannot be improved or verified as working.* Doc: Follow-through tracking record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Follow-through record review*	Reviews evidence of active confirmation that referred patients reached the receiving facility.
DOCUMENT *Non-completion response review*	Reviews the defined action taken when a referral isn't confirmed as completed.
ASK *Tracking metric interview*	Asks staff how referral follow-through is tracked and reviewed.

REFERENCES

[23] Unreconciled specialist referrals are identified as a contributing factor in a substantial share of ambulatory diagnostic-error malpractice claims, distinct from the referral decision itself.

Standard 4.8 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

A referral that's made but never confirmed leaves open the possibility that the patient never actually received the care they were referred for, and nobody at this clinic would know.

The evidence: [23] Unreconciled specialist referrals are identified as a contributing factor in a substantial share of ambulatory diagnostic-error malpractice claims, distinct from the referral decision itself.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific process actively confirms referral completion.	✗ No process exists beyond assuming the referral was completed.
✓ A defined action follows when a referral isn't confirmed.	✗ No action follows when a patient doesn't confirm as having gone.
✓ Follow-through is tracked as a specific, reviewed metric.	✗ Follow-through is not tracked at all.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Confirmation happens for urgent referrals but not routine ones.**
Routine referrals can still represent a genuine, missed diagnosis risk.

2 **A non-completion is noticed but no specific action follows.**
Noticing without acting provides limited real protection.

3 **Tracking exists but isn't regularly reviewed for patterns.**
Individual tracking without pattern review misses systemic issues.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent referrals for evidence of completion confirmation.

Week 2 Establish a specific confirmation process for all referrals, not only urgent ones.

Week 3 Define a specific action for unconfirmed referrals.

Ongoing Review follow-through tracking data periodically for patterns.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real example of a referral that wasn't completed and what happened next.
A real example, or its honest absence, reveals whether this system functions.

Check routine referrals specifically, not just urgent ones.
Routine-seeming referrals are where follow-through most commonly lapses.

E-LEARNING academy.gmj.ge/amb-std4-8-referral-followthrough — 30 min · complete before self-assessment

	Standard 4.9 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Every Test Result Reaches the Patient, Abnormal or Not**	**ASSESSMENT** ASF-AMB-STD4-v3.0 ISO 9001:2015 §8 Operation

CR FULL	TR FULL	SM FULL	ST FULL

4.9
NON-NEGOTIABLE
L1

THE STANDARD

Every Test Result Reaches the Patient, Abnormal or Not

Every laboratory or imaging result is actively communicated back to the patient through a specific, tracked process, with abnormal results reaching them faster, not slower — not left in a chart assumed to have been seen.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific, tracked process ensuring every test result reaches the patient?** *A specific, named process, not an assumption results will be seen and acted on.* Doc: Result communication process	YES	PARTIAL	NO
2	**Do abnormal results reach the patient faster than normal ones, by design?** *A specific, faster pathway for abnormal results, not the same speed for everything.* Doc: Abnormal result pathway	YES	PARTIAL	NO
3	**Is there a way to identify a result that was never actually communicated?** *A tracking mechanism that surfaces a gap, not one that only shows completed communications.* Doc: Uncommunicated result tracking	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Result communication process review*	Reviews the specific process ensuring results reach patients.
DOCUMENT *Abnormal result pathway review*	Reviews whether abnormal results follow a specifically faster pathway.
OBSERVE *Uncommunicated result check*	Checks whether the tracking system can actually surface a result that was never communicated.

REFERENCES

[24] Callen JL, Westbrook JI, Georgiou A, Li J. Failure to follow-up test results for ambulatory patients: a systematic review. J Gen Intern Med. 2011;27(10):1334-1348 — found 6.8% to 62% of laboratory results and up to 36% of radiology results in ambulatory care settings were never followed up.

Standard 4.9 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

Failure to follow up on test results is one of the most well-documented, significant patient safety gaps in ambulatory care specifically, directly linked to missed and delayed cancer diagnoses.

The evidence: [24] Callen JL, Westbrook JI, Georgiou A, Li J. Failure to follow-up test results for ambulatory patients: a systematic review. J Gen Intern Med. 2011;27(10):1334-1348 — found 6.8% to 62% of laboratory results and up to 36% of radiology results in ambulatory care settings were never followed up.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, tracked process ensures every result reaches the patient.	✗ Results are filed with no active communication process.
✓ Abnormal results follow a genuinely faster, specific pathway.	✗ Abnormal results receive no faster treatment than routine ones.
✓ The system can identify and surface an uncommunicated result.	✗ There is no way to identify a result that fell through the cracks.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 Communication happens reliably for results reviewed by the ordering clinician personally, but not for others covering.
Coverage transitions are exactly where results can fall through unnoticed.

2 An abnormal-result pathway exists but relies on someone manually noticing the abnormal flag.
Manual reliance without a systematic prompt can miss results under time pressure.

3 Tracking exists but nobody reviews it to look for gaps.
A tracking system that isn't actively reviewed doesn't function as real protection.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of recent results for evidence of actual patient communication.

Week 2 Establish a specific, faster pathway for abnormal results.

Week 3 Build a tracking mechanism that surfaces uncommunicated results.

Ongoing Review the tracking system periodically for any gap.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example and trace whether the patient actually received the result.
A real example reveals whether this is genuine practice or assumed.

Ask specifically about coverage situations — a different clinician handling a colleague's results.
This is where the process most commonly breaks down.

E-LEARNING academy.gmj.ge/amb-std4-9-test-result-followup — 30 min · complete before self-assessment

Standard 4.10 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

A Chaperone Is Genuinely Offered for Every Sensitive Examination

ASSESSMENT ASF-AMB-STD4-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

4.10
NON-NEGOTIABLE
L1

THE STANDARD

A Chaperone Is Genuinely Offered for Every Sensitive Examination

Every patient undergoing a genital, pelvic, rectal, or breast examination, or any examination they consider sensitive, is offered a trained chaperone — not assumed comfortable without one, and not left with a chaperone who is only an untrained bystander.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is a trained chaperone genuinely offered before every sensitive examination?** *Offered as standard practice, not only when a patient happens to ask.* Doc: Chaperone offer documentation	YES	PARTIAL	NO
2	**Is the chaperone a trained staff member, not a patient's own companion?** *A friend or family member is not a substitute for a trained chaperone.* Doc: Chaperone training record	YES	PARTIAL	NO
3	**Is a patient's decision to decline the chaperone genuinely respected and recorded?** *The patient's right to decline is real, not a formality.* Doc: Decline documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Chaperone offer review*	Reviews documentation for consistent chaperone offers before sensitive examinations.
DOCUMENT *Chaperone training review*	Reviews training records for staff serving as chaperones.
ASK *Patient experience interview*	Asks a patient whether a chaperone was genuinely offered for a relevant examination.

REFERENCES

[25] Established international medical ethics guidance recognizes the offer of a trained chaperone for sensitive examinations as a formal professional standard, irrespective of the gender of the clinician or patient, reflected in professional body guidance across many countries.

Standard 4.10 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

WHY THIS STANDARD EXISTS

A chaperone protects both patient dignity and safety during sensitive examinations, and functions as a genuine safeguard only when trained and consistently offered — a friend or family member accompanying the patient is not a substitute for this role.

The evidence: [25] Established international medical ethics guidance recognizes the offer of a trained chaperone for sensitive examinations as a formal professional standard, irrespective of the gender of the clinician or patient, reflected in professional body guidance across many countries.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A trained chaperone is genuinely offered before every sensitive examination.	✗ Chaperones are offered inconsistently, only when a patient happens to ask.
✓ Chaperones are trained staff, not the patient's own companion.	✗ A patient's own family member is treated as an adequate substitute.
✓ A patient's decision to decline is respected and recorded.	✗ Declining a chaperone isn't genuinely respected or documented.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Chaperones are offered for gynaecological exams but not consistently for other sensitive exams.**
Sensitivity extends beyond one specific examination type, per the patient's own perception.

2 **A chaperone is present but was never specifically trained for the role.**
An untrained bystander doesn't provide the same genuine safeguard.

3 **The offer happens but is made so casually that patients don't feel it's a genuine option.**
A genuine offer needs to feel like a real choice, not a formality to get through.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current chaperone offer practice across all relevant examination types.

Week 2 Train designated staff specifically for the chaperone role.

Week 3 Standardise how the offer is made so it feels like a genuine choice.

Ongoing Audit chaperone offer documentation periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient directly whether a chaperone was offered, not just whether one was present.
This reveals whether the offer was genuine, not just whether someone happened to be in the room.

Check chaperone training records specifically, not just presence in the room.
An untrained bystander doesn't meet this standard even if physically present.

E-LEARNING academy.gmj.ge/amb-std4-10-chaperone — 30 min · complete before self-assessment

	Standard 4.11 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **Dignity, Respect, and Non-Discrimination Are Practised, Not Just Stated**	ASSESSMENT ASF-AMB-STD4-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

4.11
NON-NEGOTIABLE
L1

THE STANDARD

Dignity, Respect, and Non-Discrimination Are Practised, Not Just Stated

Every patient is treated with dignity and respect regardless of background, and care decisions are demonstrably free of discrimination — verified through observation and patient experience, not assumed from a written policy.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a written non-discrimination policy covering care decisions specifically?** *Covering clinical care, not just a general workplace policy.* Doc: Non-discrimination policy document	YES	PARTIAL	NO
2	**Can staff describe specific ways they ensure equitable treatment?** *Concrete practices, not a general assurance.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a mechanism to report perceived discriminatory treatment specifically?** *A pathway that names discrimination directly, not folded anonymously into general feedback.* Doc: Discrimination-specific reporting mechanism	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Policy scope review*	Reviews the policy for coverage of clinical care decisions specifically.
ASK *Staff practice interview*	Asks staff to describe specific, concrete practices ensuring equitable treatment.
OBSERVE *Patient experience check*	Where possible, gathers patient feedback on whether treatment felt equitable.

REFERENCES

[26] Non-discrimination and equitable treatment are foundational patient rights principles across international healthcare quality frameworks, consistently requiring verification through actual patient experience and observed practice.

Standard 4.11 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

WHY THIS STANDARD EXISTS

A non-discrimination policy that exists only on paper protects nobody. This has to be verified through how patients are actually treated, because discrimination in healthcare rarely announces itself.

The evidence: [26] Non-discrimination and equitable treatment are foundational patient rights principles across international healthcare quality frameworks, consistently requiring verification through actual patient experience and observed practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A policy specifically covers clinical care decisions.	✗ Policy exists only for employment matters.
✓ Staff describe concrete, specific practices.	✗ Staff can only offer general assurances.
✓ A discrimination-specific reporting mechanism exists.	✗ No distinct mechanism exists for reporting discrimination.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Policy exists but was never specifically communicated to clinical staff.**
A policy that never reaches decision-makers has limited practical effect.

2 **Staff describe good intentions but struggle with specific examples.**
Genuine practice usually shows in specific examples.

3 **A reporting mechanism exists but few patients know it's available.**
Availability that isn't communicated functions similarly to unavailability.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review policy scope for coverage of clinical care decisions.

Week 2 Communicate the policy directly to clinical staff with concrete examples.

Week 3 Establish a distinct, communicated discrimination reporting mechanism.

Ongoing Gather patient feedback periodically on equitable treatment.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff for a specific example, not a general assurance.
Concrete examples distinguish genuine internalisation from stated policy.

Ask how a patient would report a discrimination concern specifically.
A distinct, known pathway is the real evidence.

E-LEARNING academy.gmj.ge/amb-std4-11-dignity — 30 min · complete before self-assessment

Standard 4.12 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Reusable Equipment Is Cleaned and Sterilised Between Patients

ASSESSMENT ASF-AMB-STD4-v3.0
ISO 9001:2015 §8 Operation

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.12
NON-NEGOTIABLE
L1

THE STANDARD

Reusable Equipment Is Cleaned and Sterilised Between Patients

All reusable equipment is cleaned and, where required, sterilised between every patient use, following a defined process, verified, not assumed from general good practice.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a defined cleaning and sterilisation process for every reusable equipment type?** *A specific process per equipment type, not a general cleaning routine.* Doc: Reprocessing protocol	YES	PARTIAL	NO
2	**Is completion of the process verified for every use, not assumed from staff following habit?** *A verification step, not reliance on memory alone.* Doc: Verification record or indicator	YES	PARTIAL	NO
3	**Is equipment that cannot be verified as properly reprocessed removed from use?** *Uncertainty should result in removal, not continued use assuming it's fine.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Reprocessing protocol review*	Reviews the defined process for each reusable equipment type.
OBSERVE *Verification step check*	Checks whether completion is genuinely verified, not assumed.
ASK *Uncertainty handling interview*	Asks staff what happens if reprocessing completion is uncertain for a specific item.

REFERENCES

[27] Standard and transmission-based precautions frameworks identify verified reprocessing of reusable equipment as a distinct, essential infection prevention control, separate from general environmental cleanliness.

Standard 4.12 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD4-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

Reusable equipment is a well-documented pathway for infection transmission between patients when cleaning and sterilisation aren't genuinely verified as complete every single time, not just usually.

The evidence: [27] Standard and transmission-based precautions frameworks identify verified reprocessing of reusable equipment as a distinct, essential infection prevention control, separate from general environmental cleanliness.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A defined process exists and is followed for every reusable equipment type.	✗ No defined process exists beyond general good practice.
✓ Completion is genuinely verified for every use.	✗ Completion is assumed from habit, never actually verified.
✓ Equipment with uncertain reprocessing is removed from use.	✗ Equipment with uncertain status continues to be used.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A process exists for the most obviously invasive equipment but not all reusable items.**
Attention concentrates on the most visible risk, missing less obvious equipment.

2 **Verification happens but isn't documented, relying on staff memory.**
Undocumented verification is hard to distinguish from assumed completion.

3 **Staff are uncertain what to do if reprocessing status is unclear for an item.**
Uncertainty without a defined response can default to continued use.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Inventory all reusable equipment and current reprocessing practice.

Week 2 Establish a defined, documented process for every equipment type.

Week 3 Build a verification step into the standard workflow.

Ongoing Audit reprocessing documentation periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the verification record for a specific piece of equipment.
A specific, documented example is the real evidence of genuine practice.

Ask what happens when reprocessing status is uncertain.
A confident, specific answer reveals whether this is genuinely handled or left to chance.

E-LEARNING academy.gmj.ge/amb-std4-12-equipment-reprocessing — 30 min · complete before self-assessment

STANDARD 5

Safety & Emergency Preparedness

MANDATORY

4 criteria

	Standard 5.1 NON-NEGOTIABLE · *Standard 5: Safety & Emergency Preparedness* **Recognising an Emergency Beyond This Clinic's Capacity**	ASSESSMENT ASF-AMB-STD5-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

5.1
NON-NEGOTIABLE
L1

THE STANDARD

Recognising an Emergency Beyond This Clinic's Capacity

Staff are trained to recognise when a patient's condition exceeds what this clinic can safely manage, with a defined, immediate escalation process to get the patient to appropriate care fast — not a generic sense that "someone will know what to do."

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Do staff have specific, trained criteria for recognising a condition beyond this clinic's capacity?** *Specific, trained criteria, not general clinical instinct alone.* Doc: Recognition criteria and training record	YES	PARTIAL	NO
2	**Is there a defined, immediate escalation process once such a condition is recognised?** *A specific, known process, not improvisation in the moment.* Doc: Escalation protocol	YES	PARTIAL	NO
3	**Do all clinical staff, not just senior ones, know this process confidently?** *Genuine, distributed readiness, not knowledge held only by the most experienced person present.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Recognition criteria review*	Reviews the specific, trained criteria for recognising a beyond-capacity condition.
DOCUMENT *Escalation protocol review*	Reviews the defined escalation process for completeness and specificity.
ASK *Staff readiness interview*	Asks a range of staff, not only senior ones, to describe the escalation process.

REFERENCES

[28] Structured recognition and escalation protocols for deteriorating patients are established practice in ambulatory and primary care safety frameworks internationally, distinct from inpatient early warning systems.

Standard 5.1 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE ASF-AMB-STD5-v3.0

WHY THIS STANDARD EXISTS

An ambulatory clinic's greatest safety risk is often not managing an emergency itself, but failing to recognise quickly enough that a patient needs a higher level of care than this clinic can provide.

The evidence: [28] Structured recognition and escalation protocols for deteriorating patients are established practice in ambulatory and primary care safety frameworks internationally, distinct from inpatient early warning systems.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff have specific, trained recognition criteria.	✗ Recognition relies on general clinical instinct with no specific criteria.
✓ A defined, immediate escalation process exists and is followed.	✗ No defined escalation process exists beyond general expectation.
✓ All clinical staff, not just senior ones, know the process confidently.	✗ Only the most senior staff member present is confident in the process.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Recognition criteria exist for the most obvious emergencies but not more subtle ones.**
Subtle deterioration is exactly where recognition gaps matter most.

2 **The escalation process is known to physicians but less consistently to support staff.**
An emergency can be first noticed by any staff member, not only clinicians.

3 **The process was trained once but never refreshed or drilled since.**
Recall under real pressure benefits from periodic reinforcement, not a single training session.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current recognition and escalation practice for specificity.

Week 2 Train all clinical and support staff on specific recognition criteria.

Week 3 Establish and brief a defined, immediate escalation process.

Ongoing Refresh training periodically, including for support staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a non-physician staff member to describe the escalation process.
This reveals whether readiness is genuinely distributed, not concentrated in one role.

Ask about a subtle, less obvious deterioration scenario.
Recognition gaps concentrate in less dramatic presentations.

E-LEARNING academy.gmj.ge/amb-std5-1-emergency-recognition — 30 min · complete before self-assessment

Standard 5.2 **NON-NEGOTIABLE** · *Standard 5: Safety & Emergency Preparedness*

Basic Resuscitation Equipment Is Ready

ASSESSMENT ASF-AMB-STD5-v3.0
ISO 9001:2015 §7 Support

CR FULL	TR FULL	SM FULL	ST FULL

5.2
NON-NEGOTIABLE
L1

THE STANDARD

Basic Resuscitation Equipment Is Ready

Basic resuscitation equipment appropriate to an ambulatory setting is checked every operating day, fully stocked and functional, with staff current on life support certification.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Is resuscitation equipment checked every operating day, with a documented record?** *Every operating day, verifiably, not "regularly."* Doc: Daily check log	YES	PARTIAL	NO
2	**Is all equipment found fully stocked and functional at each check?** *A check that finds gaps but doesn't trigger immediate resupply provides only partial protection.* Doc: Gap resolution record	YES	PARTIAL	NO
3	**Are all relevant staff current on life support certification?** *A lapsed certification discovered during an emergency is a preventable failure.* Doc: Certification tracking record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Daily check log review*	Reviews check logs for consistency across operating days.
OBSERVE *Live equipment check*	Directly inspects equipment for stock completeness and functionality.
DOCUMENT *Certification currency check*	Reviews staff certification records for lapses.

REFERENCES

[29] Resuscitation readiness protocols, including scheduled equipment checks and current life-support certification, are foundational elements of resuscitation system quality frameworks across international emergency care guidance.

Standard 5.2 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE ASF-AMB-STD5-v3.0
ISO 9001:2015 §7 Support

WHY THIS STANDARD EXISTS

Resuscitation equipment has exactly one moment where its readiness matters, with no opportunity to discover and fix a gap in that moment — a routine check that's actually followed is the only mechanism that catches a problem beforehand.

The evidence: [29] Resuscitation readiness protocols, including scheduled equipment checks and current life-support certification, are foundational elements of resuscitation system quality frameworks across international emergency care guidance.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Daily checks are documented consistently with no gaps.	✗ Check logs show gaps or inconsistent completion.
✓ Equipment is fully stocked and functional at assessment.	✗ Equipment found during assessment has missing or expired components.
✓ All relevant staff hold current life support certification.	✗ One or more staff have lapsed certification with no tracked renewal.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Checks happen consistently on weekdays but less reliably on shorter operating days.**
Any day the clinic operates carries the same real risk.

2 **Equipment is checked but gaps found aren't resolved before the next operating day.**
Detection without resolution leaves a real gap.

3 **Certification tracking exists but renewal reminders aren't proactive.**
A system that only notices a lapse after it happens offers no advance protection.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit check log completeness across all operating days.

Week 2 Establish immediate resolution for any gap found during a check.

Week 3 Build a proactive certification renewal tracking system.

Ongoing Spot-check readiness periodically, unannounced.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check logs for the clinic's shortest or least busy operating days specifically.
Routine checks can erode exactly when the day feels less demanding.

Physically inspect equipment yourself rather than relying on the log alone.
A completed log entry and genuinely current equipment aren't always the same thing.

E-LEARNING academy.gmj.ge/amb-std5-2-resuscitation-readiness — 30 min · complete before self-assessment

Standard 5.3 **NON-NEGOTIABLE** · *Standard 5: Safety & Emergency Preparedness*

Fire Safety Is Real, Not Theoretical

ASSESSMENT ASF-AMB-STD5-v3.0
ISO 9001:2015 §7 Support

CR ADAPTED	TR FULL	SM FULL	ST FULL

5.3
NON-NEGOTIABLE
L1

THE STANDARD

Fire Safety Is Real, Not Theoretical

Fire safety equipment is tested on schedule and an evacuation drill has actually been run, with real participation, not merely documented as a policy requirement.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is fire safety equipment tested on a defined schedule, with records kept?** *Extinguishers and alarms specifically, not general assumption of functionality.* Doc: Fire equipment testing log	YES	PARTIAL	NO
2	**Has an evacuation drill actually been run, with real staff participation?** *A physical drill, not a tabletop discussion of the plan.* Doc: Drill record, date and scope	YES	PARTIAL	NO
3	**Are evacuation routes kept genuinely clear, not obstructed in practice?** *A route clear on paper but blocked in reality fails when it matters.* Doc: Route clearance check	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Equipment testing record review*	Reviews fire safety equipment testing records for schedule consistency.
DOCUMENT *Drill record check*	Checks for a specific, dated evacuation drill record.
OBSERVE *Evacuation route check*	Physically checks that marked routes are genuinely clear.

REFERENCES

[30] Fire safety and evacuation drill practice are established requirements in healthcare facility safety frameworks precisely because untested procedures reliably fail to translate into effective real-world response.

Standard 5.3 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE ASF-AMB-STD5-v3.0
ISO 9001:2015 §7 Support

WHY THIS STANDARD EXISTS

Fire safety equipment that's present but untested, and evacuation procedures that exist only on paper, provide the appearance of safety without its substance.

The evidence: [30] Fire safety and evacuation drill practice are established requirements in healthcare facility safety frameworks precisely because untested procedures reliably fail to translate into effective real-world response.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Equipment is tested on a consistent, documented schedule.	✗ Testing records show gaps or don't exist.
✓ A real evacuation drill has been run, with genuine participation.	✗ No evidence of an actual physical drill, only a written plan.
✓ Evacuation routes are verified clear.	✗ Routes are found obstructed by stored equipment or furniture.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Equipment testing happens for alarms but less consistently for extinguishers.**
Different systems can develop uneven testing discipline over time.

2 **A drill was run once, historically, with no repeat since.**
Staff turnover means a single historical drill doesn't reflect current readiness.

3 **Routes are clear during quiet periods but accumulate obstruction over time.**
A route clear at one check doesn't guarantee it stays clear as operations continue.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit fire safety equipment testing records for consistency.

Week 2 Schedule and run a genuine evacuation drill if none has occurred recently.

Week 3 Establish a routine evacuation route clearance check.

Ongoing Repeat drills on a fixed schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the drill date and who participated.
Specific, dated evidence is the only real proof of practice.

Walk the evacuation routes yourself.
Obstruction accumulates gradually and may not be visible from records alone.

E-LEARNING academy.gmj.ge/amb-std5-3-fire-safety — 30 min · complete before self-assessment

	Standard 5.4 NON-NEGOTIABLE · *Standard 5: Safety & Emergency Preparedness* **Internal Emergency Alerts Are Clear and Trained**	ASSESSMENT ASF-AMB-STD5-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

5.4
NON-NEGOTIABLE
L1

THE STANDARD

Internal Emergency Alerts Are Clear and Trained

The clinic has a clearly defined internal emergency alert system, whether colour-coded or plain-language, with every staff member trained and able to respond correctly.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the clinic have a clearly documented internal emergency alert system?** *A specific, written system, not an assumption staff will understand from prior experience elsewhere.* Doc: Internal emergency alert system document	YES	PARTIAL	NO
2	**Are all staff, including part-time or covering staff, trained on this specific system?** *Facility-specific training, not reliance on what a code meant at a previous workplace.* Doc: Training record covering all staff categories	YES	PARTIAL	NO
3	**Can staff correctly state the required response for each alert type used?** *Understanding the required response, not just recognising an alert occurred.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Alert system documentation review*	Reviews the documented system for clarity and completeness.
ASK *Staff response interview*	Asks staff, including part-time staff, what a specific alert means and requires.
DOCUMENT *Training coverage check*	Reviews training records for coverage across all staff categories.

REFERENCES

[31] American Hospital Association. Hospital Emergency Codes: Moving Toward Plain Language. Chicago: AHA; 2023.

Standard 5.4 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE ASF-AMB-STD5-v3.0

WHY THIS STANDARD EXISTS

Hospital emergency codes are not internationally standardised, and what matters is not which specific system a clinic chooses, but that its own system is clearly defined, consistently used, and genuinely understood by every relevant staff member.

The evidence: [31] American Hospital Association. Hospital Emergency Codes: Moving Toward Plain Language. Chicago: AHA; 2023.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A clear, documented system exists.	✗ No documented system exists.
✓ All staff categories are trained on this specific system.	✗ Training reaches full-time staff but not part-time or covering staff.
✓ Staff correctly state the required response for each alert type.	✗ Staff recognise an alert occurred but cannot state the correct response.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The system is understood by clinical staff but not administrative staff who may also need to respond.**
Emergency response often depends on more than clinical staff alone.

2 **Training happens at induction but is never refreshed.**
Recall fades without periodic reinforcement.

3 **The system is clear for common alerts but less clear for rare ones.**
Rarely used alerts are exactly the ones most likely to be forgotten.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Document the clinic's internal emergency alert system clearly.

Week 2 Extend training to all staff categories, including part-time and covering staff.

Week 3 Consider a plain-language approach to reduce confusion given staff turnover.

Ongoing Refresh training periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a part-time or newer staff member specifically.
This is where genuine gaps in facility-specific understanding surface.

Ask about a less common alert type.
Understanding of rare alerts often lags behind common ones.

E-LEARNING academy.gmj.ge/amb-std5-4-internal-alerts — 30 min · complete before self-assessment

STANDARD 6

Aftercare & Follow-up

MANDATORY

3 criteria

	Standard 6.1 NON-NEGOTIABLE · *Standard 6: Aftercare & Follow-up* **Every Patient Leaves With a Real, Understood Plan**	ASSESSMENT ASF-AMB-STD6-v3.0 ISO 9001:2015 §8 Operation

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.1
NON-NEGOTIABLE
L1

THE STANDARD

Every Patient Leaves With a Real, Understood Plan

Every patient leaves with a documented aftercare plan they can explain back in their own words — not a printed sheet handed over on the way out the door.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does every patient receive a documented aftercare plan specific to their visit?** *Content specific to this patient's condition, not a generic sheet.* Doc: Aftercare plan sample	YES	PARTIAL	NO
2	**Can a patient contacted after the visit explain their own plan in their own words?** *Tests whether the plan was actually understood, not just handed over.* Doc: N/A — tested directly, e.g. follow-up call	YES	PARTIAL	NO
3	**Does the plan cover medication, warning signs, and who to contact if something goes wrong?** *A plan missing any of these leaves a genuine gap in what the patient needs.* Doc: Plan content checklist	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Plan content review*	Reviews a sample of aftercare plans for patient-specific content.
ASK *Patient understanding check*	Contacts a recent patient to check whether they can describe their own plan accurately.
OBSERVE *Delivery process observation*	Observes how aftercare instructions are actually delivered.

REFERENCES

[32] Discharge communication quality is consistently identified in patient safety literature as a determinant of post-discharge complications and readmission, distinct from the clinical quality of care received during the visit.

Standard 6.1 · *Standard 6: Aftercare & Follow-up*

Guidance & Learning

GUIDANCE ASF-AMB-STD6-v3.0

ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

For a single-episode ambulatory visit, the plan the patient leaves with often carries as much weight as the visit itself, especially if the patient will not have another point of contact with this clinic soon.

The evidence: [32] Discharge communication quality is consistently identified in patient safety literature as a determinant of post-discharge complications and readmission, distinct from the clinical quality of care received during the visit.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every patient receives a documented, patient-specific plan.	✗ Aftercare information is a generic printed sheet regardless of the actual visit.
✓ Patients contacted afterward can accurately describe it.	✗ Patients contacted afterward cannot describe what they were told.
✓ Plans consistently cover medication, warning signs, and contact information.	✗ Plans are missing key elements like warning signs or contact information.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Plans are individualised for complex visits but generic for routine ones.**
Perceived complexity often determines effort, though routine visits still carry real risk.

2 **The plan is thorough but delivered in the last rushed moments before the patient leaves.**
Content quality doesn't matter if delivery doesn't allow genuine understanding.

3 **Plans are given to the patient but not to an accompanying caregiver when relevant.**
A patient who is unwell may rely on whoever is caring for them afterward.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of recent aftercare plans for genuine patient-specific content.

Week 2 Build plan delivery into the visit schedule with real time allocated.

Week 3 Train staff to check patient understanding before the patient leaves.

Ongoing Spot-check patient understanding through follow-up contact.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Contact a discharged patient directly if possible.
The document proves content existed; the patient's recall proves it was understood.

Observe an actual discharge if timing allows.
Rushed delivery is a common, specific failure pattern worth seeing directly.

E-LEARNING academy.gmj.ge/amb-std6-1-aftercare-plan — 30 min · complete before self-assessment

Standard 6.2 **NON-NEGOTIABLE** · *Standard 6: Aftercare & Follow-up*

A Real Mechanism Confirms the Patient Reached Their Next Step

ASSESSMENT ASF-AMB-STD6-v3.0
ISO 9001:2015 §8 Operation

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.2
NON-NEGOTIABLE
L1

THE STANDARD

A Real Mechanism Confirms the Patient Reached Their Next Step

For any patient referred elsewhere or given a follow-up requirement, a genuine, defined mechanism confirms they actually got there — not merely available on request if the patient happens to reach back out.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a defined mechanism to actively confirm patients reached their referral or follow-up, not just availability on request?** *The clinic initiating contact, not merely being reachable if the patient calls first.* Doc: Follow-up protocol document	YES	PARTIAL	NO
2	**Does the mechanism apply consistently, not only for cases staff happen to remember?** *A system that depends on individual staff memory is not a reliable system.* Doc: Follow-up completion log	YES	PARTIAL	NO
3	**Is there a defined escalation if follow-up reveals the patient never went?** *Detecting a gap is only useful if something happens as a result.* Doc: Escalation protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Follow-up protocol and log review*	Reviews the mechanism and checks completion records against actual recent referrals.
OBSERVE *Follow-up contact sample check*	Checks whether a sample of recent patients actually received the defined follow-up contact.
ASK *Escalation protocol interview*	Asks staff what happens if follow-up reveals the patient never went.

REFERENCES

[33] Structured post-visit follow-up contact is associated with earlier identification of missed care transitions in ambulatory health services literature, distinct from the quality of the referral decision itself.

Standard 6.2 · *Standard 6: Aftercare & Follow-up*
Guidance & Learning

GUIDANCE ASF-AMB-STD6-v3.0
ISO 9001:2015 §8 Operation

WHY THIS STANDARD EXISTS

Placing the entire burden of follow-through on a patient who has just left, often unwell and unfamiliar with what happens next, means the people most at risk of a missed step are also least likely to reliably initiate contact themselves.

The evidence: [33] Structured post-visit follow-up contact is associated with earlier identification of missed care transitions in ambulatory health services literature, distinct from the quality of the referral decision itself.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A defined, proactive mechanism is applied consistently.	✗ Follow-up happens only if the patient calls back.
✓ Completion is tracked and verifiable, not dependent on memory.	✗ No tracking confirms follow-up actually happened.
✓ A clear escalation path exists and is used when a gap is found.	✗ Staff are uncertain what to do if follow-up reveals a gap.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Follow-up happens reliably for high-risk referrals but inconsistently for routine ones.**
Routine referrals still carry genuine risk of a missed step.

2 **A follow-up call is made but doesn't ask specific enough questions to confirm completion.**
A generic check-in may miss whether the patient actually went.

3 **Follow-up is attempted but not repeated if the patient doesn't answer the first call.**
A single missed attempt without a retry can leave the hardest-to-reach patients uncovered.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent referrals for evidence of actual follow-up contact.

Week 2 Define a specific follow-up mechanism, timing, and content.

Week 3 Build a tracking log so completion is verifiable.

Ongoing Review the escalation protocol periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a completion log, not a description of the intended process.
A tracked record is the only real evidence.

Ask about retry attempts for patients who don't answer the first call.
The hardest-to-reach patients are sometimes the highest-risk ones.

E-LEARNING academy.gmj.ge/amb-std6-2-followup-mechanism — 30 min · complete before self-assessment

Standard 6.3 **CORE** · *Standard 6: Aftercare & Follow-up*

Patients Can Complain After Leaving, and Complaints Are Read

ASSESSMENT ASF-AMB-STD6-v3.0
ISO 9001:2015 §9 Performance Evaluation

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.3
CORE
L1

THE STANDARD

Patients Can Complain After Leaving, and Complaints Are Read

A complaint channel exists that a patient can use after leaving the clinic, with evidence that complaints are genuinely read and acted on, not merely collected.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Can a patient submit a complaint after leaving, not only while present?** *A way to reach the clinic afterward, not only an in-person suggestion box.* Doc: Complaint channel description	YES	PARTIAL	NO
2	**Is there evidence complaints are actually read and result in a response?** *A collected complaint with no follow-through provides no real value.* Doc: Complaint response record sample	YES	PARTIAL	NO
3	**Have any complaints led to a documented change in practice?** *A system that has never led to a change is worth questioning.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Post-visit channel accessibility check*	Verifies a real, accessible way exists for a patient to submit a complaint after leaving.
DOCUMENT *Response record review*	Reviews complaints for evidence of an actual response.
DOCUMENT *Practice-change history check*	Checks for any documented instance where a complaint led to a change.

REFERENCES

[34] Patient complaint systems with demonstrated action on findings are identified in patient safety literature as a distinct quality signal from complaint volume alone.

Standard 6.3 · *Standard 6: Aftercare & Follow-up*

Guidance & Learning

GUIDANCE ASF-AMB-STD6-v3.0

ISO 9001:2015 §9 Performance Evaluation

WHY THIS STANDARD EXISTS

A complaint channel only available while physically present misses concerns that surface once a patient has had time to reflect, and a channel that collects complaints without follow-through teaches patients their feedback doesn't matter.

The evidence: [34] Patient complaint systems with demonstrated action on findings are identified in patient safety literature as a distinct quality signal from complaint volume alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A clear, accessible channel exists for patients after they've left.	✗ No channel exists beyond an in-person suggestion box.
✓ Sampled complaints show genuine responses.	✗ Complaints are collected but show no evidence of response.
✓ At least one documented instance exists of a complaint leading to change.	✗ Nobody can recall a complaint ever leading to change.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A channel exists but isn't clearly communicated to patients before they leave.**
Availability patients don't know about functions like unavailability.

2 **Complaints receive acknowledgment but not a substantive response.**
A form-letter acknowledgment can satisfy the letter without real value.

3 **Serious complaints are reviewed; minor ones accumulate without individual response.**
Complaints below a threshold shouldn't disappear entirely.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current channel accessibility, particularly for patients who've left.

Week 2 Ensure the channel is clearly communicated as part of the visit.

Week 3 Establish a defined response process and timeframe.

Ongoing Track whether complaints lead to real practice changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how a patient would actually find and use the channel.
Theoretical availability and genuine accessibility aren't always the same.

Ask for a specific example of a complaint that changed something.
A real example reveals more than a description of the process.

E-LEARNING academy.gmj.ge/amb-std6-3-complaints — 30 min · complete before self-assessment

STANDARD 7

Governance & Management

MANDATORY

9 criteria

Standard 7.1 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Leadership Is Real and Accountable

ASSESSMENT ASF-AMB-STD7-v3.0
ISO 9001:2015 §5 Leadership

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

7.1
NON-NEGOTIABLE
L1

THE STANDARD

Leadership Is Real and Accountable

The clinic has clear, named clinical and operational leadership with defined authority over safety and quality — not an informal arrangement functioning without real oversight structure.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a named person with defined authority over clinical safety and quality?** *A specific name and defined authority, not an informal arrangement.* Doc: Leadership structure document	YES	PARTIAL	NO
2	**Does this person actively review quality and safety matters, not only administrative ones?** *Genuine engagement with quality, not administration alone.* Doc: Quality review record	YES	PARTIAL	NO
3	**Is there a documented process for raising a safety concern to this leadership?** *A specific, known pathway, not an assumption someone would eventually hear about it.* Doc: Escalation pathway document	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Leadership structure review*	Reviews the named leadership structure and defined authority.
ASK *Leadership engagement interview*	Asks the named leader to describe a recent quality or safety issue they addressed.
OBSERVE *Escalation pathway check*	Checks whether staff know how to raise a safety concern to leadership.

REFERENCES

[35] Jha AK, Epstein AM. Hospital governance and the quality of care. Health Aff (Millwood). 2010;29(1):182-187.

Standard 7.1 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE ASF-AMB-STD7-v3.0
ISO 9001:2015 §5 Leadership

WHY THIS STANDARD EXISTS

Without clear leadership accountability, there is no mechanism above day-to-day clinical activity responsible for safety and quality — a small clinic can drift without anyone noticing precisely because no one is specifically responsible for noticing. For a genuine solo practitioner, Adapted does not mean this requirement is waived — it means the practitioner explicitly, formally acknowledges in writing that they hold this responsibility themselves, rather than it remaining an unstated assumption. For a small team of two to five, Adapted means one person is clearly named, even if that person also does clinical work.

The evidence: [35] Jha AK, Epstein AM. Hospital governance and the quality of care. Health Aff (Millwood). 2010;29(1):182-187.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A named person holds clear, defined safety and quality authority.	✗ No specific person holds this authority; it's informally diffuse.
✓ This person actively engages with real quality and safety matters.	✗ Leadership engagement is limited to administrative matters.
✓ Staff know a specific pathway for raising a safety concern.	✗ Staff are unsure how a safety concern would ever reach leadership.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A named leader exists but spends most time on clinical duties, with little time for oversight.**
A title without real time devoted to the function provides limited real oversight.

2 **An escalation pathway exists but has never actually been used or tested.**
An untested pathway may not translate smoothly into real use.

3 **Leadership reviews quality data but rarely acts visibly on findings.**
Review without visible action provides limited real improvement.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Confirm and document named leadership and defined authority.

Week 2 Establish a specific, communicated escalation pathway for safety concerns.

Week 3 Build genuine time for quality and safety oversight into leadership's role.

Ongoing Track leadership follow-through on identified issues.

For Micro (solo) Write a single, dated statement naming yourself as the accountable person for safety and quality at this practice, and set a recurring time on your own calendar to actually act on it — this alone satisfies the requirement genuinely.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the named leader for a specific, real example of addressing a safety issue.
A real example reveals genuine engagement versus a title alone.

Ask front-line staff how they'd escalate a concern.
Staff-side confirmation reveals whether the pathway genuinely functions.

E-LEARNING academy.gmj.ge/amb-std7-1-leadership — 30 min · complete before self-assessment

	Standard 7.2 **NON-NEGOTIABLE** · *Standard 7: Governance & Management* **Policy Actually Gets Followed**	**ASSESSMENT** ASF-AMB-STD7-v3.0 ISO 9001:2015 §7 Support

CR FULL	TR FULL	SM FULL	ST FULL

7.2
NON-NEGOTIABLE
L1

THE STANDARD

Policy Actually Gets Followed

A policy framework exists and staff can describe how it's genuinely applied in practice, not merely confirm that policies are filed and technically available.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Can staff describe how a specific, named policy is actually applied in their daily work?** *Not whether they know a policy exists — whether they can describe applying it.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is there a mechanism to check policy adherence, not just policy existence?** *A genuine audit or spot-check process, distinct from confirming documents are filed.* Doc: Policy adherence audit record	YES	PARTIAL	NO
3	**When a policy-practice gap is found, is there a defined response?** *Identifying a gap without addressing it provides limited real value.* Doc: Gap resolution record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Staff application interview*	Asks staff to describe how they actually apply a specific named policy.
DOCUMENT *Adherence audit review*	Checks for evidence of a process verifying policy adherence.
OBSERVE *Practice-policy comparison*	Observes an area and compares actual behaviour against stated policy.

REFERENCES

[36] Policy-practice gaps are consistently identified in healthcare quality literature as a distinct failure mode from policy absence.

Standard 7.2 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE ASF-AMB-STD7-v3.0
ISO 9001:2015 §7 Support

WHY THIS STANDARD EXISTS

A policy nobody follows provides the appearance of governance without its function — the real question is whether staff behaviour actually reflects it, which is a fundamentally different, harder thing to verify than confirming a document exists.

The evidence: [36] Policy-practice gaps are consistently identified in healthcare quality literature as a distinct failure mode from policy absence.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff describe genuine application of policy in their actual work.	✗ Staff confirm policies exist but cannot describe how they apply.
✓ A real adherence-checking mechanism exists.	✗ No mechanism exists to verify adherence beyond filing.
✓ Identified gaps trigger a defined, followed response.	✗ Known gaps persist without any response.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Policies are followed for established practices but not consistently for newer ones.**
Habit reinforces old adherence; new policies need active reinforcement.

2 **An adherence check exists but only samples an easily-prepared subset.**
A narrow or predictable scope can miss where real gaps live.

3 **Gaps are identified but corrective action isn't tracked to completion.**
Identification without follow-through leaves the underlying gap unresolved.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Select key policies and ask a sample of staff to describe actual application.

Week 2 Establish a genuine adherence-checking mechanism.

Week 3 Build a tracked resolution process for identified gaps.

Ongoing Rotate which policies get checked.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about application, not existence.
These surface very different answers.

Pick a policy area to observe directly, not just review on paper.
Direct observation reveals gaps document review cannot.

E-LEARNING academy.gmj.ge/amb-std7-2-policy-adherence — 30 min · complete before self-assessment

	Standard 7.3 **NON-NEGOTIABLE** · *Standard 7: Governance & Management* **Patient Information Stays Private**	**ASSESSMENT** ASF-AMB-STD7-v3.0

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

7.3
NON-NEGOTIABLE
L1

THE STANDARD

Patient Information Stays Private

Confidentiality is protected physically and culturally throughout the clinic, not only referenced in a written policy that doesn't translate into actual practice.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are screens and monitors positioned so patient information isn't visible to others?** *Physical positioning, checked directly.* Doc: Photo audit of screen positioning	YES	PARTIAL	NO
2	**Are clinical conversations conducted where they can't be overheard?** *Doors or private spaces genuinely used, not just available.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Do staff apply confidentiality practices consistently, not only when reminded?** *Habitual, not situational.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Physical privacy check*	Walks through patient-facing areas checking screen positioning and conversation privacy.
OBSERVE *Conversation audibility check*	Checks whether conversations can be overheard from adjacent areas.
ASK *Staff practice interview*	Asks staff to describe specific privacy practices.

REFERENCES

[37] Patient confidentiality protection frameworks consistently identify physical environment design and staff behaviour, not policy documentation alone, as the practical determinants of actual privacy protection.

Standard 7.3 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE ASF-AMB-STD7-v3.0

WHY THIS STANDARD EXISTS

A confidentiality policy that exists on paper while screens face waiting areas and conversations happen within earshot provides no real protection.

The evidence: [37] Patient confidentiality protection frameworks consistently identify physical environment design and staff behaviour, not policy documentation alone, as the practical determinants of actual privacy protection.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Screens are consistently positioned away from public view.	✗ Screens face waiting areas, visible to anyone passing.
✓ Clinical conversations happen in genuinely private spaces.	✗ Conversations are regularly audible to other patients.
✓ Staff describe habitual privacy practices without prompting.	✗ Staff can cite policy but describe no specific habits.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Physical privacy is good in exam rooms but overlooked at the reception counter.**
Privacy protection is often strongest where it was deliberately designed.

2 **Staff are conscientious when reminded but inconsistent otherwise.**
Habitual practice is more reliable than reminded practice.

3 **A private space exists but isn't consistently used under time pressure.**
Infrastructure for privacy doesn't guarantee its use during a busy day.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit screen positioning and conversation privacy across all patient-facing areas.

Week 2 Reposition screens and reinforce private space use where gaps are found.

Week 3 Brief staff on habitual, not just reminded, confidentiality practice.

Ongoing Spot-check physical privacy periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Walk the space as a visitor would.
A familiar routine can make an obvious privacy gap invisible to staff.

Ask staff for specific examples of their own privacy practices.
Specific habits reveal genuine internalisation better than reciting policy.

E-LEARNING academy.gmj.ge/amb-std7-3-confidentiality — 30 min · complete before self-assessment

Standard 7.4 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Medical Records Are Complete and Secure

ASSESSMENT ASF-AMB-STD7-v3.0
ISO 9001:2015 §7 Support

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.4
NON-NEGOTIABLE
L1

THE STANDARD

Medical Records Are Complete and Secure

Records contain all mandatory elements, are regularly audited for completeness, and are protected by access controls and a genuine breach response plan.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Is there a defined list of mandatory record elements, audited regularly?** *A specific, checkable list and genuine audit, not assumed completeness.* Doc: Mandatory elements list and audit record	YES	PARTIAL	NO
2	**Are access controls in place restricting data access to staff who need it for their role?** *Role-based restriction, not general access available to anyone.* Doc: Access control policy and implementation	YES	PARTIAL	NO
3	**Is there a documented, specific breach response plan?** *A named process, not a general statement of concern.* Doc: Breach response plan document	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Completeness audit review*	Reviews audit records for genuine, regular practice.
DOCUMENT *Access control review*	Reviews access control policy against actual staff access levels.
DOCUMENT *Breach response plan check*	Reviews the plan for specificity and actionable steps.

REFERENCES

[38] Health information security frameworks consistently identify access control and incident response planning, rather than technology sophistication alone, as the primary determinants of practical data protection in resource-constrained settings.

Standard 7.4 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE ASF-AMB-STD7-v3.0
ISO 9001:2015 §7 Support

WHY THIS STANDARD EXISTS

An incomplete or insecure record is a quiet risk — the information a future clinician needs might simply not be there, or might be exposed to someone with no legitimate need to see it.

The evidence: [38] Health information security frameworks consistently identify access control and incident response planning, rather than technology sophistication alone, as the primary determinants of practical data protection in resource-constrained settings.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Regular, genuine completeness audits are conducted.	✗ No audit process exists, or completeness is assumed.
✓ Access controls are genuinely role-based.	✗ Data access is broadly available regardless of role.
✓ A specific, actionable breach response plan exists.	✗ No breach response plan exists beyond vague concern.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Audits happen but only sample a small, unrepresentative set of records.**
A narrow sample can miss where real gaps concentrate.

2 **Access controls exist for electronic records but not physical files.**
Security attention often concentrates on digital systems.

3 **A breach plan exists but has never been reviewed since written.**
An unreviewed plan may not reflect current systems or risk.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review the mandatory elements list and recent audit practice.

Week 2 Establish a genuine, regular completeness audit.

Week 3 Review access controls against actual staff roles.

Ongoing Review the breach response plan periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for actual audit records, not a description of intended process.
Dated findings are the only real evidence.

Check physical record access, not only electronic systems.
Security attention often skews toward digital systems while physical files remain loosely controlled.

E-LEARNING academy.gmj.ge/amb-std7-4-records-security — 30 min · complete before self-assessment

Standard 7.5 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Incidents Are Actually Reported

ASSESSMENT ASF-AMB-STD7-v3.0

ISO 9001:2015 §10 Improvement

CR FULL	TR FULL	SM FULL	ST FULL

7.5

NON-NEGOTIABLE

L1

THE STANDARD

Incidents Are Actually Reported

An accessible incident reporting system exists and staff genuinely use it — measured by real reporting volume and pattern, not merely by the system's technical availability.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the incident reporting system genuinely accessible to all staff?** *Accessible at the point of work, not buried in an administrative system.* Doc: Reporting system access description	YES	PARTIAL	NO
2	**Does actual reporting volume suggest genuine use?** *A system receiving almost no reports over time suggests a use problem, not perfect safety.* Doc: Reporting volume data over time	YES	PARTIAL	NO
3	**Do staff believe they can report without fear of punitive consequence?** *Genuine psychological safety, not just a stated non-punitive policy.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Reporting volume review*	Reviews reporting volume and pattern over time for genuine use.
ASK *Psychological safety interview*	Asks staff directly whether they feel safe reporting an incident, including one they caused.
OBSERVE *System accessibility check*	Checks how accessible the reporting mechanism is at the actual point of work.

REFERENCES

[39] Incident reporting culture, specifically the psychological safety staff feel around reporting without fear of punitive consequence, is consistently identified as the primary determinant of reporting volume, more so than system accessibility alone.

Standard 7.5 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE ASF-AMB-STD7-v3.0
ISO 9001:2015 §10 Improvement

WHY THIS STANDARD EXISTS

An incident reporting system nobody uses provides no safety value regardless of how well-designed it is — the real barrier to reporting is almost always fear of blame, not the mechanics of the form.

The evidence: [39] Incident reporting culture, specifically the psychological safety staff feel around reporting without fear of punitive consequence, is consistently identified as the primary determinant of reporting volume, more so than system accessibility alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Reporting volume reflects genuine, ongoing use.	✗ Reporting volume is minimal or has dropped sharply with no explanation.
✓ Staff describe genuine confidence in reporting without punitive consequence.	✗ Staff describe fear of blame as a reason they hesitate to report.
✓ The system is accessible at the point of work.	✗ The system is difficult to access in practice.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Reporting happens for minor incidents but staff hesitate to report their own errors.**
Psychological safety often varies by perceived personal exposure.

2 **Senior staff report reliably; junior staff report far less.**
Hierarchy can create very different real experiences within the same clinic.

3 **A non-punitive policy exists but staff recall a past incident where reporting led to consequences.**
A single remembered punitive response can undermine trust for a long time afterward.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review reporting volume trends for concerning patterns.

Week 2 Interview a cross-section of staff, including junior staff, about reporting confidence.

Week 3 Address any specific past incident undermining psychological safety.

Ongoing Track reporting volume, investigating any significant drop.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask junior staff specifically, not only senior staff.
Hierarchy can create very different real experiences.

Ask about reporting one's own error specifically.
Self-reporting confidence is usually the harder, more revealing test.

E-LEARNING academy.gmj.ge/amb-std7-5-incident-reporting — 30 min · complete before self-assessment

Standard 7.6 **CORE** · *Standard 7: Governance & Management*

Staff Scope of Practice Is Verified

ASSESSMENT ASF-AMB-STD7-v3.0
ISO 9001:2015 §7 Support

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.6
CORE
L1

THE STANDARD

Staff Scope of Practice Is Verified

Every clinical staff member's actual duties are matched to their verified scope of practice and licence category, not assumed appropriate because they've been performing the role for some time.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is each staff member's actual duties matched against their verified licence category and scope?** *A specific comparison, not an assumption that current duties are appropriate.* Doc: Scope of practice review record	YES	PARTIAL	NO
2	**Is this comparison repeated periodically, not only done once at hiring?** *Duties can expand gradually over time without a formal decision ever being made.* Doc: Periodic review schedule	YES	PARTIAL	NO
3	**Is there a defined process if a mismatch is found?** *Identifying a mismatch without correcting it provides no real protection.* Doc: Correction process record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Scope comparison review*	Reviews evidence that actual duties are compared against verified scope.
DOCUMENT *Periodic review schedule check*	Checks whether this comparison is repeated periodically.
ASK *Correction process interview*	Asks what happens if a mismatch between duties and scope is found.

REFERENCES

[40] Scope-of-practice verification, distinct from initial credential checking, is an established governance requirement in healthcare workforce quality frameworks internationally.

Standard 7.6 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE ASF-AMB-STD7-v3.0
ISO 9001:2015 §7 Support

WHY THIS STANDARD EXISTS

A staff member performing tasks beyond their actual licensed scope — even competently, even for years — represents a real, unaddressed risk that only surfaces when something goes wrong, and by then the gap has often existed unnoticed for a long time.

The evidence: [40] Scope-of-practice verification, distinct from initial credential checking, is an established governance requirement in healthcare workforce quality frameworks internationally.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Duties are specifically matched against verified scope for every staff member.	✗ No specific comparison exists beyond assumed appropriateness.
✓ This comparison is repeated periodically, not only at hiring.	✗ Comparison happens only once, at hiring.
✓ A defined correction process exists and is used when a mismatch is found.	✗ No process exists to correct an identified mismatch.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Comparison happens for physicians but less consistently for support clinical staff.**
Attention often concentrates on the most visible role.

2 **A mismatch was identified once but never actually corrected.**
Identification without correction leaves the underlying risk in place.

3 **Duties have gradually expanded informally without anyone reviewing scope.**
Gradual, informal expansion is exactly the pattern this criterion exists to catch.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current duties against verified scope for all clinical staff.

Week 2 Correct any mismatch found.

Week 3 Establish a periodic review schedule.

Ongoing Repeat scope reviews on the defined schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a staff member to describe their actual daily duties in detail.
A detailed description can reveal drift a job title alone wouldn't show.

Check non-physician clinical staff specifically.
Scope drift often goes unnoticed longest in less closely supervised roles.

E-LEARNING academy.gmj.ge/amb-std7-6-scope-of-practice — 30 min · complete before self-assessment

Standard 7.7 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Leadership Reviews Overall Performance at Planned Intervals

ASSESSMENT ASF-AMB-STD7-v3.0
ISO 9001:2015 §9 Performance Evaluation

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

7.7
NON-NEGOTIABLE
L1

THE STANDARD

Leadership Reviews Overall Performance at Planned Intervals

Clinic leadership formally reviews overall quality and safety performance at a defined, regular interval — not only in reaction to an individual incident — covering trends, not single events.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does leadership review overall quality and safety performance at a defined, regular interval?** *A specific, planned interval, not only when something goes wrong.* Doc: Management review schedule and minutes	YES	PARTIAL	NO
2	**Does the review cover trends and patterns, not only a list of individual incidents?** *Trend analysis reveals patterns a single-incident view misses entirely.* Doc: Trend analysis documentation	YES	PARTIAL	NO
3	**Does the review lead to documented decisions or actions, not just discussion?** *Review without resulting action provides limited real value.* Doc: Review outcome and action record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Review schedule and minutes review*	Reviews evidence of a genuine, planned-interval management review, not only reactive incident discussion.
DOCUMENT *Trend coverage check*	Checks whether reviews cover trends and patterns, not only individual events.
ASK *Outcome interview*	Asks leadership for a specific example of a decision or action resulting from a review.

REFERENCES

[41] International Organization for Standardization. ISO 9001:2015 — Quality management systems — Requirements. 5th ed. Geneva: ISO; 2015 — Clause 9.3 requires management review of the quality management system's performance at planned intervals, distinct from reactive incident response.

Standard 7.7 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE ASF-AMB-STD7-v3.0

ISO 9001:2015 §9 Performance Evaluation

WHY THIS STANDARD EXISTS

Reacting to individual incidents as they happen is necessary but not sufficient — without a periodic step back to review the whole picture, a slow decline across many small, individually unremarkable events can go unnoticed until it becomes a serious pattern. For a genuine solo practitioner, Adapted does not mean skipping this because there is no one to review with — it means blocking real, dedicated time, alone, on a fixed schedule, to look back through recent cases, complaints, and near-misses as a genuine reviewer of your own practice, not just as the clinician who lived through each one individually.

The evidence: [41] International Organization for Standardization. ISO 9001:2015 — Quality management systems — Requirements. 5th ed. Geneva: ISO; 2015 — Clause 9.3 requires management review of the quality management system's performance at planned intervals, distinct from reactive incident response.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Reviews happen at a genuine, defined, regular interval.	✗ No planned review exists beyond reacting to individual incidents.
✓ Reviews cover trends and patterns across time.	✗ Reviews, if they happen, only list individual events without trend analysis.
✓ Reviews lead to documented decisions or actions.	✗ Reviews produce discussion but no documented follow-through.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A review happens but only when leadership happens to have time, not on a fixed schedule.**
An irregular pattern risks the review being deprioritised indefinitely during busy periods.

2 **Trends are informally noticed but never formally analysed or documented.**
Undocumented pattern recognition is hard to distinguish from coincidence.

3 **Decisions are made during review but not tracked to completion afterward.**
A decision without follow-through tracking often quietly doesn't happen.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Establish a specific, regular interval for a genuine performance review.

Week 2 Build a simple trend-analysis method covering incidents, complaints, and quality data together.

Week 3 Define how review decisions will be tracked to completion.

Ongoing Hold the review on schedule and track action completion.

For Micro (solo) Block a specific, recurring date on your own calendar — quarterly is reasonable — and use that time to read back through the last quarter's incidents, complaints, and near-misses as a reviewer would, not as you experienced them in the moment.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual review schedule and minutes, not a description of intended practice.
Dated records are the only real evidence of a consistent, planned process.

Ask for a specific example of a decision that came from a review, not an incident.
This distinguishes genuine systematic review from incident-reactive management alone.

E-LEARNING academy.gmj.ge/amb-std7-7-management-review — 30 min · complete before self-assessment

Standard 7.8 **CORE** · *Standard 7: Governance & Management*

Quality Objectives Are Set, Specific, and Tracked

ASSESSMENT ASF-AMB-STD7-v3.0
ISO 9001:2015 §6 Planning

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

7.8
CORE
L1

THE STANDARD

Quality Objectives Are Set, Specific, and Tracked

The clinic sets specific, measurable quality objectives for the coming period, and tracks progress against them — not a general aspiration to "provide good care" with no way to know if it's actually happening.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Are there specific, measurable quality objectives set for the coming period?** *A specific, numeric or otherwise measurable target, not a general aspiration.* Doc: Quality objectives document	YES	PARTIAL	NO
2	**Is progress against these objectives actually tracked?** *Tracked progress, not an assumption things are improving.* Doc: Progress tracking record	YES	PARTIAL	NO
3	**Are objectives communicated to relevant staff, not held only by leadership?** *Staff who don't know the objective can't meaningfully contribute to it.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Objectives specificity review*	Reviews whether objectives are genuinely specific and measurable, not general aspirations.
DOCUMENT *Progress tracking review*	Reviews evidence of actual tracked progress against objectives.
ASK *Staff awareness interview*	Asks relevant staff whether they know the clinic's current quality objectives.

REFERENCES

[42] International Organization for Standardization. ISO 9001:2015 — Quality management systems — Requirements. 5th ed. Geneva: ISO; 2015 — Clause 6.2 requires quality objectives that are measurable, monitored, and communicated, distinct from general quality aspirations.

Standard 7.8 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE ASF-AMB-STD7-v3.0
ISO 9001:2015 §6 Planning

WHY THIS STANDARD EXISTS

A general commitment to quality provides no way to know whether things are actually improving, staying flat, or quietly getting worse — specific, measurable objectives are what make quality something the clinic can actually manage, not just hope for. For a genuine solo practitioner, Adapted means the objective is written down and specific even though only one person will ever see it — a private, specific goal still counts, and still needs to be genuinely measurable, not a vague intention.

The evidence: [42] International Organization for Standardization. ISO 9001:2015 — Quality management systems — Requirements. 5th ed. Geneva: ISO; 2015 — Clause 6.2 requires quality objectives that are measurable, monitored, and communicated, distinct from general quality aspirations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Objectives are specific and genuinely measurable.	✗ Objectives, if stated, are general aspirations with no measurable target.
✓ Progress is actively tracked, not assumed.	✗ No tracking exists beyond a general sense of how things are going.
✓ Relevant staff know the current objectives.	✗ Staff are unaware any specific objectives exist.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Objectives are set but not revisited until the following year.**
Infrequent revisiting limits the ability to course-correct during the period.

2 **Objectives are measurable but tracking happens informally without documentation.**
Undocumented tracking is hard to distinguish from not tracking at all.

3 **Leadership knows the objectives but they were never communicated to front-line staff.**
Objectives staff don't know about can't meaningfully shape their daily work.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current quality objectives, if any, for genuine specificity and measurability.

Week 2 Set or refine specific, measurable objectives for the coming period.

Week 3 Communicate objectives to relevant staff and establish a tracking method.

Ongoing Track progress and revisit objectives at defined intervals.

For Micro (solo) Write one or two specific, measurable objectives for the coming period, even though you're the only person who will track them — for example, a specific target for test-result turnaround time or patient complaint response time.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual objectives, with numbers or specific targets, not a general statement.
Specificity is what distinguishes a real objective from an aspiration.

Ask a front-line staff member if they know the current objective.
This reveals whether objectives genuinely reach beyond leadership.

E-LEARNING academy.gmj.ge/amb-std7-8-quality-objectives — 30 min · complete before self-assessment

Standard 7.9 **CORE** · *Standard 7: Governance & Management*

A Continual Improvement Process Exists, Not Only Reaction to Individual Incidents

ASSESSMENT ASF-AMB-STD7-v3.0
ISO 9001:2015 §10 Improvement

CR N/A	TR FULL	SM ADAPTED	ST FULL

7.9
CORE
L1

THE STANDARD

A Continual Improvement Process Exists, Not Only Reaction to Individual Incidents

The clinic has a defined process for identifying and acting on improvement opportunities generally, separate from and in addition to responding to specific incidents as they occur.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a defined process for identifying improvement opportunities, separate from incident response?** *A proactive process, not only reaction to something having gone wrong.* Doc: Continual improvement process document	YES	PARTIAL	NO
2	**Have any improvements been made through this process recently, not only through incident-driven correction?** *A real, recent example distinguishes genuine practice from a policy on paper.* Doc: Recent improvement example	YES	PARTIAL	NO
3	**Are staff able to suggest improvement ideas through a known channel?** *Front-line staff often see improvement opportunities leadership doesn't.* Doc: Staff suggestion channel	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Improvement process review*	Reviews the defined process for identifying improvement opportunities separate from incidents.
DOCUMENT *Recent example review*	Reviews for a real, recent example of proactive, non-incident-driven improvement.
ASK *Staff suggestion channel interview*	Asks staff whether they know how to suggest an improvement idea.

REFERENCES

[43] International Organization for Standardization. ISO 9001:2015 — Quality management systems — Requirements. 5th ed. Geneva: ISO; 2015 — Clause 10.3 requires continual improvement of the quality management system's suitability, adequacy, and effectiveness, as a distinct requirement from corrective action on nonconformities.

Standard 7.9 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE ASF-AMB-STD7-v3.0
ISO 9001:2015 §10 Improvement

WHY THIS STANDARD EXISTS

Reacting only to incidents means the clinic only improves in response to something already having gone wrong — a genuine continual improvement process looks for opportunities to get better even where nothing has yet failed. For a genuine solo practitioner, Adapted means replacing team-based suggestion mechanisms with a real substitute — patient feedback is often the most honest and available source of improvement ideas when there's no colleague to raise them with you.

The evidence: [43] International Organization for Standardization. ISO 9001:2015 — Quality management systems — Requirements. 5th ed. Geneva: ISO; 2015 — Clause 10.3 requires continual improvement of the quality management system's suitability, adequacy, and effectiveness, as a distinct requirement from corrective action on nonconformities.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A defined, proactive improvement process exists, distinct from incident response.	✗ No improvement happens outside of reacting to specific incidents.
✓ A real, recent example of proactive improvement can be shown.	✗ No recent example of proactive improvement exists.
✓ Staff know a specific channel for suggesting improvements.	✗ Staff have no known way to suggest an improvement idea.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A suggestion channel exists but has never actually been used.**
An unused channel may not be genuinely known or trusted by staff.

2 **Improvement happens but is driven entirely by leadership, without staff input.**
Front-line perspective often surfaces different opportunities than leadership sees.

3 **A process exists on paper but the clinic cannot point to a real recent example.**
A theoretical process and a genuinely functioning one are different things.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for any proactive, non-incident-driven improvement activity.

Week 2 Establish a specific staff suggestion channel if none exists.

Week 3 Define a process for evaluating and acting on improvement suggestions.

Ongoing Track and document real examples of proactive improvement.

For Micro (solo) Use patient feedback specifically as your improvement input channel — actively ask a few patients each month what could have gone better, and keep a simple, dated log of ideas this surfaces and what you actually changed as a result.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example that wasn't triggered by an incident.
This is the clearest test of whether improvement is genuinely proactive.

Ask a front-line staff member how they'd suggest an improvement idea.
A confident, specific answer reveals whether the channel is genuinely known.

E-LEARNING academy.gmj.ge/amb-std7-9-continual-improvement — 30 min · complete before self-assessment

Endorsements

What follows are optional endorsements — additional standards layered on top of the base seven, never issued alone. A facility must genuinely pass Standards 1 through 7 before any endorsement below is assessed. "Ambulatory Clinic" alone means the base seven only. "Ambulatory Clinic + Dental" means the base seven, verified first, plus the endorsement that follows.

STANDARD 8

Dental Practice

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

5 criteria

	Standard 8.1 NON-NEGOTIABLE · *Standard 8: Dental Practice* **Dental Instrument Sterilization Is Monitored, Not Just Performed**	ASSESSMENT ASF-AMB-STD8-v3.0
CR ADAPTED	TR FULL	SM FULL / ST FULL

8.1
NON-NEGOTIABLE
L1

THE STANDARD

Dental Instrument Sterilization Is Monitored, Not Just Performed

Sterilization of reusable dental instruments is verified through mechanical, chemical, and biological monitoring together, on a defined schedule, with results documented — not assumed complete because the sterilizer cycle finished.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every sterilization cycle monitored using mechanical, chemical, and biological indicators together, not just one?** *All three layers together — a completed cycle alone doesn't confirm sterility was achieved.* Doc: Sterilization monitoring log	YES	PARTIAL	NO
2	**Is a biological indicator run at least weekly, per manufacturer and international guidance?** *Biological testing is the only method that directly confirms spore-killing capability.* Doc: Biological indicator test record	YES	PARTIAL	NO
3	**When a monitoring result is inadequate, are affected instrument packs reprocessed before any use on a patient?** *An inadequate result without reprocessing defeats the purpose of monitoring at all.* Doc: Reprocessing record following a failed result	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Monitoring log review*	Reviews the sterilization monitoring log for consistent use of all three monitoring types.
DOCUMENT *Biological indicator frequency check*	Confirms biological indicator testing happens at least weekly with matching control records.
OBSERVE *Failed-result response check*	Checks whether any past inadequate result led to genuine reprocessing before patient use.

REFERENCES

[44] Kohn WG, Collins AS, Cleveland JL, Harte JA, Eklund KJ, Malvitz DM. Guidelines for Infection Control in Dental Health-Care Settings — 2003. MMWR Recomm Rep. 2003;52(RR-17):1-61 — establishes combined mechanical, chemical, and biological sterilization monitoring, with biological indicator testing at minimum weekly, as the standard of care.

Standard 8.1 · *Standard 8: Dental Practice*
Guidance & Learning

GUIDANCE ASF-AMB-STD8-v3.0

WHY THIS STANDARD EXISTS

A sterilizer that completes its cycle can still fail to actually sterilize its contents, and the only way to know is to monitor for it deliberately — mechanical readings alone don't confirm a spore-killing result, which is why international guidance requires layering all three monitoring types together.

The evidence: [44] Kohn WG, Collins AS, Cleveland JL, Harte JA, Eklund KJ, Malvitz DM. Guidelines for Infection Control in Dental Health-Care Settings — 2003. MMWR Recomm Rep. 2003;52(RR-17):1-61 — establishes combined mechanical, chemical, and biological sterilization monitoring, with biological indicator testing at minimum weekly, as the standard of care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ All three monitoring types are used together, consistently, for every cycle.	✗ Only mechanical readings are checked, with no chemical or biological monitoring.
✓ Biological indicator testing happens at least weekly with proper controls.	✗ Biological indicator testing happens rarely or inconsistently.
✓ Any inadequate result triggers genuine reprocessing before instruments are used.	✗ An inadequate monitoring result was noted but instruments were used regardless.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Mechanical and chemical monitoring happen consistently, but biological testing lapses during busy periods.**
Biological testing is the only method confirming actual sterilizing capability — the other two only confirm the cycle ran.

2 **Monitoring happens but records aren't consistently dated or retained.**
Undocumented monitoring is difficult to distinguish from monitoring that didn't happen.

3 **The practice has a clear process but staff performing monitoring were never formally trained on it.**
A correct process followed by an untrained person is more likely to drift over time.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current sterilization monitoring practice against all three required indicator types.

Week 2 Establish or correct a weekly biological indicator testing schedule.

Week 3 Train staff performing monitoring and define the reprocessing response to any inadequate result.

Ongoing Maintain dated monitoring records and review for consistency.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual dated monitoring log, not a description of the process.
Dated records are the only real evidence of consistent practice.

Ask specifically about the last biological indicator result and what would happen if it failed.
A confident, specific answer reveals genuine understanding versus a memorized policy line.

E-LEARNING academy.gmj.ge/amb-std8-1-sterilization-monitoring — 30 min · complete before self-assessment

Standard 8.2 **NON-NEGOTIABLE** · *Standard 8: Dental Practice*

Aerosol-Generating Procedures Have Real Ventilation and PPE Control

ASSESSMENT ASF-AMB-STD8-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

8.2
NON-NEGOTIABLE
L1

THE STANDARD

Aerosol-Generating Procedures Have Real Ventilation and PPE Control

Procedures that generate dental aerosols use a defined combination of high-volume evacuation, appropriate respiratory protection, and adequate room ventilation or recovery time between patients — not standard surgical masks alone.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is high-volume evacuation used consistently during aerosol-generating procedures?** *Consistent use, not reserved for occasional cases.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is respiratory protection appropriate to aerosol exposure used, not a standard surgical mask alone?** *A specific, higher level of protection matched to genuine aerosol risk.* Doc: PPE protocol document	YES	PARTIAL	NO
3	**Is there a defined recovery time or ventilation standard between patients in the same treatment space?** *A specific, followed interval, not an assumption the air clears quickly enough.* Doc: Room turnover protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Aerosol procedure observation*	Observes an aerosol-generating procedure for consistent evacuation and PPE use.
DOCUMENT *PPE protocol review*	Reviews the protocol for appropriate respiratory protection specific to aerosol exposure.
DOCUMENT *Room turnover review*	Reviews the defined recovery time or ventilation standard between patients.

REFERENCES

[45] Kohn WG, Collins AS, Cleveland JL, Harte JA, Eklund KJ, Malvitz DM. Guidelines for Infection Control in Dental Health-Care Settings — 2003. MMWR Recomm Rep. 2003;52(RR-17):1-61 — identifies aerosol and spatter-generating dental procedures as requiring specific engineering and personal protective controls beyond standard precautions.

Standard 8.2 · *Standard 8: Dental Practice*
Guidance & Learning

GUIDANCE ASF-AMB-STD8-v3.0

WHY THIS STANDARD EXISTS

Dental aerosols carry a genuine, well-documented transmission risk distinct from droplet contact alone, and standard infection control precautions built for droplet exposure don't fully address it — this requires its own deliberate combination of controls.

The evidence: [45] Kohn WG, Collins AS, Cleveland JL, Harte JA, Eklund KJ, Malvitz DM. Guidelines for Infection Control in Dental Health-Care Settings — 2003. MMWR Recomm Rep. 2003;52(RR-17):1-61 — identifies aerosol and spatter-generating dental procedures as requiring specific engineering and personal protective controls beyond standard precautions.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ High-volume evacuation is used consistently during every aerosol-generating procedure.	✗ Evacuation is used inconsistently or only for select cases.
✓ Respiratory protection matched to aerosol risk is used, not a standard mask alone.	✗ Standard surgical masks are relied on for aerosol-generating procedures.
✓ A specific, followed room turnover interval exists between patients.	✗ No defined recovery time exists between patients in the same space.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Evacuation is used for most procedures but skipped for quick, perceived-low-risk ones.**
Aerosol generation depends on the procedure type, not how quick it feels.

2 **Respiratory protection is available but not consistently worn by all staff present.**
Protection that exists but isn't consistently used provides limited real protection.

3 **A turnover interval exists but is shortened under scheduling pressure.**
A protocol that erodes under pressure isn't a reliable protocol.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current aerosol procedure practice against evacuation, PPE, and turnover standards.

Week 2 Address any gaps in evacuation use or respiratory protection.

Week 3 Establish and communicate a specific room turnover interval.

Ongoing Observe practice periodically, particularly during busy scheduling periods.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe during a genuinely busy period, not a quiet one.
Protocol discipline is most likely to erode under real scheduling pressure.

Check whether the turnover interval is actually followed, not just written down.
A written interval that's routinely shortened in practice doesn't provide real protection.

E-LEARNING academy.gmj.ge/amb-std8-2-aerosol-control — 30 min · complete before self-assessment

	Standard 8.3 **NON-NEGOTIABLE** · *Standard 8: Dental Practice* **Every Dental X-Ray Is Justified, Not Routine**	**ASSESSMENT** ASF-AMB-STD8-v3.0

CR ADAPTED	**TR** FULL	**SM** FULL	**ST** FULL

8.3
NON-NEGOTIABLE
L1

THE STANDARD

Every Dental X-Ray Is Justified, Not Routine

Every dental radiograph is individually justified by clinical need, not taken as a routine default, with dose kept as low as reasonably achievable and equipment subject to regular quality control.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is each radiograph justified by a specific clinical reason, documented, not taken as a routine default for every visit?** *A specific, recorded clinical reason for this patient, this visit.* Doc: Radiograph justification documentation	YES	PARTIAL	NO
2	**Is prior imaging reviewed before ordering a new radiograph, to avoid unnecessary repeat exposure?** *Checking existing images first, not defaulting to a new exposure.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is X-ray equipment subject to regular quality control and calibration?** *Verified equipment performance, not assumed from the image looking acceptable.* Doc: Equipment quality control record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Justification documentation review*	Reviews a sample of patient records for documented, specific justification of each radiograph.
ASK *Prior imaging review interview*	Asks staff whether prior imaging is checked before ordering a new radiograph.
DOCUMENT *Equipment quality control review*	Reviews quality control and calibration records for X-ray equipment.

REFERENCES

[46] International Atomic Energy Agency. Radiation protection of patients in dental radiology. Vienna: IAEA — establishes that routine dental X-ray examination for all patients is not justified, and that individual justification combined with dose optimisation (ALARA) is the primary determinant of patient radiation safety in dentistry.

Standard 8.3 · *Standard 8: Dental Practice*

Guidance & Learning

GUIDANCE ASF-AMB-STD8-v3.0

WHY THIS STANDARD EXISTS

The single most effective way to reduce a patient's radiation exposure over a lifetime of dental care is avoiding unnecessary radiographs in the first place — this matters more than any specific shielding practice, which is why international radiation protection guidance leads with justification, not equipment.

The evidence: [46] International Atomic Energy Agency. Radiation protection of patients in dental radiology. Vienna: IAEA — establishes that routine dental X-ray examination for all patients is not justified, and that individual justification combined with dose optimisation (ALARA) is the primary determinant of patient radiation safety in dentistry.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every radiograph has a specific, documented clinical justification.	✗ Radiographs are taken as a routine part of every visit, without specific justification.
✓ Prior imaging is checked before ordering new radiographs.	✗ No check of prior imaging happens before ordering a new exposure.
✓ Equipment undergoes regular, documented quality control.	✗ Equipment quality control is irregular or undocumented.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Justification is documented for complex cases but defaults to routine for standard check-ups.**
Routine visits still require individual justification under the same principle.

2 **Prior imaging exists but isn't consistently checked before a new order.**
An available record that isn't checked provides no real protection against unnecessary exposure.

3 **Equipment quality control happened once at installation but hasn't been repeated.**
Equipment performance can drift over years of use without ongoing verification.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent radiographs for documented, specific justification.

Week 2 Establish a routine check of prior imaging before ordering new radiographs.

Week 3 Schedule or verify regular equipment quality control.

Ongoing Audit justification documentation periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the specific clinical reason behind a recent radiograph, not a general policy statement.
A specific, patient-level reason is the real evidence of individual justification.

Ask when equipment quality control was last performed, with a date.
A vague answer suggests this isn't a genuinely maintained, ongoing practice.

E-LEARNING academy.gmj.ge/amb-std8-3-radiography-safety — 30 min · complete before self-assessment

	Standard 8.4 **NON-NEGOTIABLE** · *Standard 8: Dental Practice* **Extraction and Surgical Consent Covers Real, Procedure-Specific Risk**	**ASSESSMENT** ASF-AMB-STD8-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

8.4
NON-NEGOTIABLE
L1

THE STANDARD

Extraction and Surgical Consent Covers Real, Procedure-Specific Risk

Consent for extraction or other invasive dental procedures includes a genuine conversation about procedure-specific risks — infection, prolonged bleeding, nerve involvement where relevant — not a generic consent form covering "dental treatment" broadly.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does consent for an invasive procedure specifically name that procedure's real risks, not a generic "dental treatment" consent?** *Named, specific risks for this specific procedure.* Doc: Procedure-specific consent record	YES	PARTIAL	NO
2	**Can the patient explain back what the specific procedure involves and its main risks?** *Tests genuine understanding, not just a signature.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Where nerve involvement or other procedure-specific risk is relevant, is it specifically discussed?** *Named directly, not folded into a general risk statement.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Consent specificity review*	Reviews consent records for procedure-specific content, not generic treatment consent.
ASK *Patient understanding check*	Asks a patient to explain back what their specific procedure involves and its main risks.
OBSERVE *Consent conversation observation*	Observes an actual consent conversation for genuine, procedure-specific discussion.

REFERENCES

[16, 47] World Health Organization. WHO guidelines for safe surgery 2009: safe surgery saves lives. Geneva: WHO; 2009 — establishes genuine, procedure-specific informed consent as a precondition of safe invasive care, not an administrative formality covering treatment broadly.

Standard 8.4 · *Standard 8: Dental Practice*

Guidance & Learning

GUIDANCE ASF-AMB-STD8-v3.0

WHY THIS STANDARD EXISTS

A generic consent form signed for "dental treatment" doesn't reflect genuine understanding of what a specific invasive procedure actually risks — extraction and surgical procedures carry real, distinct risks a routine filling doesn't, and consent has to reflect that difference honestly.

The evidence: [16, 47] World Health Organization. WHO guidelines for safe surgery 2009: safe surgery saves lives. Geneva: WHO; 2009 — establishes genuine, procedure-specific informed consent as a precondition of safe invasive care, not an administrative formality covering treatment broadly.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Consent specifically names the procedure and its real, relevant risks.	✗ Consent is a generic form covering "dental treatment" broadly.
✓ Patients can explain back the specific procedure and its main risks.	✗ Patients cannot describe what their specific procedure involves.
✓ Procedure-specific risks like nerve involvement are directly discussed where relevant.	✗ Relevant specific risks are never named directly.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Consent is procedure-specific for major surgical cases but generic for routine extractions.**
Even a routine extraction carries real, procedure-specific risk worth naming directly.

2 **Risks are named on the form but not genuinely discussed in conversation.**
A form listing risks isn't the same as a patient understanding them.

3 **Consent happens well before the procedure but isn't reconfirmed if circumstances change.**
Genuine consent should reflect the procedure actually being performed, not one discussed weeks earlier.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current consent documentation for genuine procedure specificity.

Week 2 Build procedure-specific consent content for common invasive procedures.

Week 3 Train staff to verify patient understanding, not just obtain a signature.

Ongoing Spot-check patient understanding after consent conversations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the patient, not the clinician, to describe the procedure and its risks.
This tests actual understanding, not staff confidence in their own explanation.

Compare consent content across a routine extraction and a more complex surgical case.
Genuinely different content reveals real specificity; near-identical text reveals a generic form.

E-LEARNING academy.gmj.ge/amb-std8-4-surgical-consent — 30 min · complete before self-assessment

Standard 8.5 **NON-NEGOTIABLE** · *Standard 8: Dental Practice*

Amalgam Waste Is Captured and Disposed of Correctly

ASSESSMENT ASF-AMB-STD8-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

8.5
NON-NEGOTIABLE
L1

THE STANDARD

Amalgam Waste Is Captured and Disposed of Correctly

Where dental amalgam is used, a compliant amalgam separator captures waste before it enters the wastewater stream, and all amalgam waste is collected and forwarded to a licensed recycler, not discharged or discarded as general waste.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is a compliant amalgam separator installed and functioning wherever amalgam is used or removed?** *Installed and genuinely functioning, not present but bypassed or unmaintained.* Doc: Amalgam separator installation and maintenance record	YES	PARTIAL	NO
2	**Is all amalgam waste — capsules, chairside traps, extracted teeth with amalgam — collected and forwarded to a licensed recycler?** *All amalgam waste categories, not only the most visible one.* Doc: Licensed recycler collection record	YES	PARTIAL	NO
3	**Is the amalgam separator maintained and replaced on the manufacturer's recommended schedule?** *A separator that isn't maintained loses its capture effectiveness over time.* Doc: Separator maintenance schedule	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Separator installation check*	Physically confirms a compliant amalgam separator is installed and functioning.
DOCUMENT *Recycler collection record review*	Reviews records confirming amalgam waste is forwarded to a licensed recycler.
DOCUMENT *Separator maintenance review*	Reviews maintenance and replacement records against manufacturer schedule.

REFERENCES

[48] Minamata Convention on Mercury. Geneva: United Nations Environment Programme; 2013, Article 4, Annex A, Part II — requires ratifying countries to implement measures for the environmentally sound management of dental amalgam waste, including the use of amalgam separators.

Standard 8.5 · *Standard 8: Dental Practice*
Guidance & Learning

GUIDANCE ASF-AMB-STD8-v3.0

WHY THIS STANDARD EXISTS

Dental amalgam waste entering the wastewater stream or general waste is a genuine, internationally recognised environmental and public health concern — this isn't a matter of local preference, it is the subject of a binding international treaty specifically because of documented, serious harm from uncontrolled mercury release.

The evidence: [48] Minamata Convention on Mercury. Geneva: United Nations Environment Programme; 2013, Article 4, Annex A, Part II — requires ratifying countries to implement measures for the environmentally sound management of dental amalgam waste, including the use of amalgam separators.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A compliant, functioning amalgam separator is installed wherever needed.	✗ No amalgam separator is installed, or it is present but not functioning.
✓ All categories of amalgam waste are collected and sent to a licensed recycler.	✗ Amalgam waste, or some categories of it, are discarded as general waste.
✓ Separator maintenance follows the manufacturer's schedule, with records kept.	✗ Separator maintenance is irregular or undocumented.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A separator is installed but hasn't been serviced on schedule.**
Capture effectiveness declines as a separator reaches its capacity without replacement.

2 **Amalgam capsules are properly collected but extracted teeth with amalgam restorations are not.**
All amalgam-containing waste categories carry the same real environmental concern.

3 **Collection happens but the recycler used isn't verified as licensed for this purpose.**
An unverified disposal pathway doesn't confirm the waste is actually being managed safely.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Confirm amalgam separator installation and current functioning status.

Week 2 Verify the recycler used is licensed and confirm collection covers all amalgam waste categories.

Week 3 Establish or correct a separator maintenance schedule.

Ongoing Maintain dated records of separator maintenance and recycler collection.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the amalgam separator directly, not just documentation of its purchase.
A separator that exists on paper but isn't installed or functioning provides no real protection.

Ask specifically about extracted teeth with amalgam restorations.
This category of amalgam waste is the most commonly overlooked in practice.

E-LEARNING academy.gmj.ge/amb-std8-5-amalgam-waste — 30 min · complete before self-assessment

STANDARD 9

Aesthetic & Injectable Medicine

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

4 criteria

Standard 9.1 **NON-NEGOTIABLE** · *Standard 9: Aesthetic & Injectable Medicine*

A Licensed Physician Oversees Every Injection, Even If Not the Injector

ASSESSMENT ASF-AMB-STD9-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

9.1
NON-NEGOTIABLE
L1

THE STANDARD

A Licensed Physician Oversees Every Injection, Even If Not the Injector

A licensed physician holds genuine, documented oversight of every injectable procedure performed at this facility, whether or not the physician personally administers each injection — not an arrangement where trained staff inject with no real physician accountability.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a specific, named licensed physician with documented oversight of injectable procedures here?** *A specific person and a real, checkable oversight relationship, not an assumed general affiliation.* Doc: Physician oversight documentation	YES	PARTIAL	NO
2	**If a non-physician performs the injection, is the physician's oversight genuine and immediate, not remote or after the fact?** *Real-time availability and accountability, not a signature reviewed days later.* Doc: Oversight protocol document	YES	PARTIAL	NO
3	**Can the physician describe their actual involvement in a recent case, specifically?** *A real, specific example, not a general description of the arrangement.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Oversight documentation review*	Reviews documentation naming the specific overseeing physician and the nature of their oversight.
ASK *Physician involvement interview*	Asks the physician to describe their actual, specific involvement in a recent injectable case.
OBSERVE *Real-time availability check*	Checks whether physician oversight is genuinely immediate during procedures, not remote.

REFERENCES

[49] Goodman GJ, Liew S, Callan P, Hart S. Facial aesthetic injections in clinical practice: Pretreatment and posttreatment consensus recommendations to minimise adverse outcomes. Australas J Dermatol. 2020;61(3):217-225 — establishes physician-level clinical oversight, proper patient selection, and technique as core risk-reduction requirements for injectable treatment.

Standard 9.1 · *Standard 9: Aesthetic & Injectable Medicine*

Guidance & Learning

GUIDANCE ASF-AMB-STD9-v3.0

WHY THIS STANDARD EXISTS

Marketing titles and private training certificates don't establish genuine medical oversight, and serious complications from injectables — vascular occlusion, tissue necrosis, vision loss — require real physician-level clinical judgement to prevent and manage, not just technical injection skill.

The evidence: [49] Goodman GJ, Liew S, Callan P, Hart S. Facial aesthetic injections in clinical practice: Pretreatment and posttreatment consensus recommendations to minimise adverse outcomes. Australas J Dermatol. 2020;61(3):217-225 — establishes physician-level clinical oversight, proper patient selection, and technique as core risk-reduction requirements for injectable treatment.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, named physician holds genuine, documented oversight.	✗ No specific physician is named; oversight is a vague, general claim.
✓ Oversight is real-time and immediate when a non-physician injects.	✗ Oversight exists only as after-the-fact paperwork review.
✓ The physician can describe specific, real involvement in recent cases.	✗ The physician cannot describe any specific recent involvement.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A physician is named but is rarely physically present during procedures.**
Named oversight without genuine availability doesn't provide real protection during a complication.

2 **Oversight is real for complex procedures but looser for routine ones.**
Complications can occur even in routine cases; the oversight standard shouldn't depend on perceived complexity.

3 **The physician reviews cases in batches at the end of the week.**
Delayed review cannot catch or respond to a complication as it's actually happening.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Confirm and document the specific overseeing physician and their real availability.

Week 2 Establish a real-time oversight protocol for non-physician injectors.

Week 3 Brief all staff on the specific oversight arrangement and escalation process.

Ongoing Review oversight genuineness periodically, including physician availability records.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the physician for a specific, recent case example, not a general description.
Specificity reveals whether oversight is genuine or a formality.

Ask a non-physician injector how they'd reach the physician during a complication, right now.
A confident, specific answer reveals genuine real-time oversight.

E-LEARNING academy.gmj.ge/amb-std9-1-physician-oversight — 30 min · complete before self-assessment

	Standard 9.2 NON-NEGOTIABLE · *Standard 9: Aesthetic & Injectable Medicine* **Injectable Products Are Sourced From Verified, Traceable Suppliers**	ASSESSMENT ASF-AMB-STD9-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

9.2
NON-NEGOTIABLE
L1

THE STANDARD

Injectable Products Are Sourced From Verified, Traceable Suppliers

Every injectable product used is sourced from a verified, traceable supplier, with batch and lot records retained — not purchased through unverified channels where authenticity cannot be confirmed.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every injectable product sourced from a verified, traceable supplier, not an unverified or informal channel?** *A checkable, legitimate supply chain, not just a lower price.* Doc: Supplier verification record	YES	PARTIAL	NO
2	**Are batch and lot numbers retained for every product used, linked to the patient record?** *Traceability that would allow a recall or adverse event investigation to actually work.* Doc: Batch and lot tracking record	YES	PARTIAL	NO
3	**Can staff describe how they'd recognise a counterfeit or suspicious product?** *Genuine awareness, not an assumption that sourcing alone guarantees authenticity.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Supplier verification review*	Reviews documentation confirming products are sourced from verified suppliers.
DOCUMENT *Batch tracking review*	Reviews batch and lot records for completeness and linkage to patient records.
ASK *Counterfeit awareness interview*	Asks staff how they would recognise a suspicious or counterfeit product.

REFERENCES

[50] Counterfeit injectable products, including unapproved botulinum toxin and dermal filler formulations, are a recognised and actively monitored risk in aesthetic medicine, with regulatory bodies issuing specific warnings to both practitioners and patients about verifying product source and authenticity before use.

Standard 9.2 · *Standard 9: Aesthetic & Injectable Medicine*

Guidance & Learning

GUIDANCE ASF-AMB-STD9-v3.0

WHY THIS STANDARD EXISTS

Counterfeit botulinum toxin and dermal filler products are a real, documented risk — unverified sourcing means a facility cannot actually confirm what's being injected into a patient, regardless of how skilled the injector is.

The evidence: [50] Counterfeit injectable products, including unapproved botulinum toxin and dermal filler formulations, are a recognised and actively monitored risk in aesthetic medicine, with regulatory bodies issuing specific warnings to both practitioners and patients about verifying product source and authenticity before use.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ All products are sourced from verified, traceable suppliers.	✗ Sourcing channels cannot be verified or are informal.
✓ Batch and lot records are complete and linked to patient records.	✗ Batch and lot records are incomplete or not retained.
✓ Staff describe genuine awareness of counterfeit product risk.	✗ Staff show no awareness of counterfeit product risk.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Primary products are verified but occasional supplementary products are not.**
Every injectable product carries the same real authenticity risk, not only the primary ones.

2 **Batch numbers are recorded but not consistently linked to the specific patient treated.**
Traceability requires the link to the patient, not just the product record alone.

3 **Verification happened once at the start of a supplier relationship but isn't ongoing.**
A supplier's legitimacy isn't guaranteed to remain constant without periodic reconfirmation.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current suppliers for all injectable products against verification standards.

Week 2 Establish batch and lot tracking linked to patient records.

Week 3 Train staff on recognising counterfeit or suspicious product indicators.

Ongoing Periodically reconfirm supplier legitimacy.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual supplier verification and batch records, not a general assurance.
Documented, specific records are the only real evidence of genuine traceability.

Ask staff directly what would make them suspicious of a product's authenticity.
Genuine awareness reveals itself in specific, real answers, not a memorized policy line.

E-LEARNING academy.gmj.ge/amb-std9-2-product-sourcing — 30 min · complete before self-assessment

Standard 9.3 **NON-NEGOTIABLE** · *Standard 9: Aesthetic & Injectable Medicine*

Vascular Occlusion Is Recognised and Treated Within Minutes, Not Hours

ASSESSMENT ASF-AMB-STD9-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

9.3
NON-NEGOTIABLE
L1

THE STANDARD

Vascular Occlusion Is Recognised and Treated Within Minutes, Not Hours

Staff performing filler injections are specifically trained to recognise the signs of vascular occlusion immediately, with hyaluronidase or the appropriate emergency treatment genuinely available on-site — not requiring the patient to be sent elsewhere before treatment can begin.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are staff specifically trained to recognise the early signs of vascular occlusion during and immediately after injection?** *Specific, trained recognition, not general awareness that complications exist.* Doc: Vascular occlusion recognition training record	YES	PARTIAL	NO
2	**Is hyaluronidase, or the appropriate treatment for the products used, genuinely available on-site, not requiring off-site sourcing?** *Immediately available, not something ordered after a complication is recognised.* Doc: On-site emergency treatment stock record	YES	PARTIAL	NO
3	**Is there a defined, immediate escalation process if a suspected occlusion doesn't respond to initial treatment?** *A specific next step, not uncertainty about what happens if first-line treatment isn't enough.* Doc: Escalation protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Recognition training review*	Reviews training records for specific vascular occlusion recognition, not general complication awareness.
OBSERVE *On-site treatment stock check*	Physically confirms hyaluronidase or appropriate treatment is genuinely on-site and in date.
ASK *Escalation protocol interview*	Asks staff what happens if a suspected occlusion doesn't respond to initial treatment.

REFERENCES

[51] Goodman GJ, Liew S, Callan P, Hart S. Facial aesthetic injections in clinical practice: Pretreatment and posttreatment consensus recommendations to minimise adverse outcomes. Australas J Dermatol. 2020;61(3):217-225 — identifies prompt recognition and treatment of vascular occlusion, including high-dose hyaluronidase availability, as critical to preventing permanent tissue damage.

Standard 9.3 · *Standard 9: Aesthetic & Injectable Medicine*

Guidance & Learning

GUIDANCE ASF-AMB-STD9-v3.0

WHY THIS STANDARD EXISTS

Vascular occlusion is the most serious acute complication of filler injection, and the window for effective treatment is measured in hours, not days — delayed recognition or treatment can result in permanent tissue necrosis or vision loss that timely intervention could have prevented.

The evidence: [51] Goodman GJ, Liew S, Callan P, Hart S. Facial aesthetic injections in clinical practice: Pretreatment and posttreatment consensus recommendations to minimise adverse outcomes. Australas J Dermatol. 2020;61(3):217-225 — identifies prompt recognition and treatment of vascular occlusion, including high-dose hyaluronidase availability, as critical to preventing permanent tissue damage.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff are specifically trained to recognise early signs of vascular occlusion.	✗ Training covers general complications without specific occlusion recognition.
✓ Appropriate emergency treatment is genuinely on-site and in date.	✗ Emergency treatment isn't on-site or is expired.
✓ A specific, known escalation process exists beyond initial treatment.	✗ Staff are uncertain what happens if initial treatment isn't sufficient.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Training happened once at hiring but hasn't been refreshed since.**
Rapid recognition under real pressure benefits from periodic reinforcement, not a single training session.

2 **Hyaluronidase is stocked but its expiry date wasn't recently checked.**
Expired emergency treatment provides no real protection when actually needed.

3 **Recognition training is strong for the injector but not for supporting staff who might notice symptoms first.**
A patient may report symptoms to any staff member present, not only the injector.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current vascular occlusion recognition training for specificity and recency.

Week 2 Confirm on-site emergency treatment stock and expiry dates.

Week 3 Establish and brief staff on a specific escalation protocol.

Ongoing Refresh recognition training periodically, including for supporting staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual hyaluronidase stock and check its expiry date directly.
Physical verification is the only real evidence of genuine on-site availability.

Ask a supporting staff member, not just the injector, how they'd recognise a complication.
This reveals whether recognition training genuinely reaches everyone present, not just the injector.

E-LEARNING academy.gmj.ge/amb-std9-3-vascular-occlusion — 30 min · complete before self-assessment

Standard 9.4 **CORE** · *Standard 9: Aesthetic & Injectable Medicine*

Patients Are Screened for Genuine Medical Suitability Before Treatment

ASSESSMENT ASF-AMB-STD9-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

9.4
CORE
L1

THE STANDARD

Patients Are Screened for Genuine Medical Suitability Before Treatment

Every patient undergoes a genuine medical suitability screening before treatment — relevant medical history, medications, prior reactions — not a booking process that moves directly from consultation to injection with no real screening step.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does every patient undergo a genuine medical suitability screening before treatment, not just a booking conversation?** *A real, structured screening step, not an informal chat covering only what the patient happens to mention.* Doc: Screening documentation	YES	PARTIAL	NO
2	**Does screening specifically cover relevant medications, prior reactions, and medical conditions that change risk?** *Specific, relevant questions, not a generic intake form.* Doc: Screening content review	YES	PARTIAL	NO
3	**Where screening identifies a relevant risk factor, does this genuinely change the treatment decision?** *Screening that never changes an outcome isn't providing real protection.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Screening documentation review*	Reviews a sample of patient records for genuine, structured screening before treatment.
DOCUMENT *Screening content review*	Reviews the screening tool for coverage of medications, prior reactions, and relevant conditions.
ASK *Risk-factor response interview*	Asks staff for a real example where screening identified a risk factor that changed the treatment plan.

REFERENCES

[52] Goodman GJ, Liew S, Callan P, Hart S. Facial aesthetic injections in clinical practice: Pretreatment and posttreatment consensus recommendations to minimise adverse outcomes. Australas J Dermatol. 2020;61(3):217-225 — identifies careful pretreatment patient selection as an essential risk-reduction step, distinct from general consultation.

Standard 9.4 · *Standard 9: Aesthetic & Injectable Medicine*

Guidance & Learning

GUIDANCE ASF-AMB-STD9-v3.0

WHY THIS STANDARD EXISTS

Certain medical conditions, medications, and prior reactions genuinely change the risk profile of an injectable procedure, and a booking process that skips real screening treats every patient as equally low-risk, which they are not.

The evidence: [52] Goodman GJ, Liew S, Callan P, Hart S. Facial aesthetic injections in clinical practice: Pretreatment and posttreatment consensus recommendations to minimise adverse outcomes. Australas J Dermatol. 2020;61(3):217-225 — identifies careful pretreatment patient selection as an essential risk-reduction step, distinct from general consultation.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every patient undergoes genuine, structured screening before treatment.	✗ Screening is informal or skipped, moving directly to treatment.
✓ Screening specifically covers medications, prior reactions, and relevant conditions.	✗ Screening content is generic and doesn't probe relevant risk factors.
✓ A real example exists of screening changing a treatment decision.	✗ No example exists of screening ever changing a treatment decision.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Screening happens for new patients but isn't repeated for returning ones.**
A patient's medical situation can change meaningfully between visits.

2 **Screening covers medications but not prior reaction history specifically.**
Prior reaction history is one of the strongest predictors of future risk.

3 **Screening identifies a risk factor but the decision to proceed anyway isn't documented with reasoning.**
Undocumented reasoning makes it impossible to confirm the decision was genuinely considered.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current screening practice for genuine structure and content.

Week 2 Build or strengthen a screening tool covering medications, prior reactions, and relevant conditions.

Week 3 Establish screening for returning patients, not only new ones.

Ongoing Document reasoning whenever a screening-identified risk factor doesn't change the treatment decision.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real example where screening changed what was done for a patient.
A real example reveals whether screening is genuine practice or a formality.

Check whether screening is repeated for returning patients.
This is a common, specific gap — screening often concentrates only on new-patient intake.

E-LEARNING academy.gmj.ge/amb-std9-4-patient-screening — 30 min · complete before self-assessment

STANDARD 10

Longevity & IV Therapy

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

4 criteria

Standard 10.1 **NON-NEGOTIABLE** · *Standard 10: Longevity & IV Therapy*

IV Line Insertion and Site Care Follow Recognised Infusion Standards

ASSESSMENT ASF-AMB-STD10-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

10.1
NON-NEGOTIABLE
L1

THE STANDARD

IV Line Insertion and Site Care Follow Recognised Infusion Standards

IV line insertion, site selection, and ongoing site care follow a recognised, evidence-based infusion therapy standard — aseptic technique, appropriate site selection, and defined site monitoring — not informal practice varying by whoever happens to be inserting the line.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does IV insertion follow a recognised aseptic technique standard, applied consistently by every staff member who inserts lines?** *A recognised standard, applied consistently — not technique that varies by individual.* Doc: IV insertion protocol document	YES	PARTIAL	NO
2	**Is the insertion site selected and assessed against defined criteria, not simply whichever vein is easiest to access?** *Site selection based on vessel health and treatment need, not convenience alone.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is the IV site monitored on a defined schedule for signs of complication, with a specific response if found?** *A defined monitoring schedule and response, not informal checking.* Doc: Site monitoring record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Insertion technique observation*	Observes an actual IV insertion for aseptic technique and site selection practice.
DOCUMENT *Monitoring schedule review*	Reviews the defined site monitoring schedule and recent monitoring records.
ASK *Complication response interview*	Asks staff what happens when site monitoring identifies a possible complication.

REFERENCES

[53] Gorski LA, Hadaway L, Hagle ME, Broadhurst D, Clare S, Kleidon T, et al. Infusion Therapy Standards of Practice, 8th Edition. J Infus Nurs. 2021;44(suppl 1):S1-S224.

Standard 10.1 · *Standard 10: Longevity & IV Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD10-v3.0

WHY THIS STANDARD EXISTS

Peripheral IV access is one of the most common invasive procedures performed anywhere in healthcare, and despite how routine it feels, it carries a real, well-documented failure and complication rate — infection, phlebitis, infiltration — that a consistent, evidence-based technique measurably reduces.

The evidence: [53] Gorski LA, Hadaway L, Hagle ME, Broadhurst D, Clare S, Kleidon T, et al. Infusion Therapy Standards of Practice, 8th Edition. J Infus Nurs. 2021;44(suppl 1):S1-S224.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Insertion technique is consistent and follows a recognised standard.	✗ Insertion technique varies significantly by individual staff member.
✓ Site selection is based on defined criteria, not convenience alone.	✗ Site selection has no defined criteria beyond ease of access.
✓ Site monitoring happens on a defined schedule with a real response process.	✗ No defined monitoring schedule exists, or findings don't trigger any response.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Technique is consistent for straightforward insertions but varies more for difficult access cases.**
Difficult access is exactly where technique consistency matters most for reducing complications.

2 **Monitoring happens but isn't documented, relying on staff memory.**
Undocumented monitoring is difficult to distinguish from monitoring that didn't happen.

3 **A response process exists for infection signs but not for infiltration or phlebitis specifically.**
Each complication type has a real, distinct pattern staff should be watching for and responding to.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current insertion and site care practice against the recognised standard.

Week 2 Standardise technique and site selection criteria across all staff who insert lines.

Week 3 Establish a defined, documented site monitoring schedule.

Ongoing Audit monitoring documentation and technique consistency periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual insertion if timing allows, not just a description of policy.
Real practice sometimes diverges meaningfully from stated policy.

Ask about a specific difficult-access case and how it was handled.
This reveals whether the standard genuinely holds under real, harder conditions.

E-LEARNING academy.gmj.ge/amb-std10-1-iv-line-care — 30 min · complete before self-assessment

Standard 10.2 **NON-NEGOTIABLE** · *Standard 10: Longevity & IV Therapy*

Hormone and Peptide Products Are Sourced From Licensed, Regulated Suppliers Only

ASSESSMENT ASF-AMB-STD10-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

10.2
NON-NEGOTIABLE
L1

THE STANDARD

Hormone and Peptide Products Are Sourced From Licensed, Regulated Suppliers Only

Every hormone, peptide, or compounded product used is sourced exclusively from a licensed, regulated compounding or manufacturing facility recognized by the relevant national medicines regulatory authority — never from research-use-only vendors, overseas suppliers, or any source without verifiable regulatory standing, regardless of cost or convenience.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every hormone or peptide product sourced from a licensed, regulated compounding or manufacturing facility, verifiable by name?** *A specific, named, licensed source — not "we have a supplier."* Doc: Supplier licensing verification	YES	PARTIAL	NO
2	**Are research-use-only or overseas-sourced products genuinely excluded, not used under a different label?** *Genuine exclusion, not the same product relabelled or described differently.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does documentation retain certificates of analysis or equivalent verification for products used?** *Real, retained verification, not assumed from the supplier's reputation alone.* Doc: Certificate of analysis records	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Supplier licensing verification*	Reviews documentation confirming every supplier's specific, current regulatory licensing status.
DOCUMENT *Certificate of analysis review*	Reviews retained certificates of analysis or equivalent verification records.
ASK *Sourcing awareness interview*	Asks staff to name the specific licensed source for a product currently in use.

REFERENCES

[54] Unregulated peptide and hormone sourcing, including research-use-only vendors and overseas suppliers, is documented to carry real risks of incorrect product identity, contamination, and dosing error, with licensed, regulated compounding and manufacturing facilities recognized by the relevant national medicines regulatory authority representing the only verifiable, regulated sourcing channel.

Standard 10.2 · *Standard 10: Longevity & IV Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD10-v3.0

WHY THIS STANDARD EXISTS

Products sourced outside licensed, regulated channels carry no verified purity, sterility, or dosing accuracy — documented cases include incorrect peptide identity, bacterial contamination, and mislabelled compounds, and "research use only" labelling does not provide any real protection when a product is actually used clinically.

The evidence: [54] Unregulated peptide and hormone sourcing, including research-use-only vendors and overseas suppliers, is documented to carry real risks of incorrect product identity, contamination, and dosing error, with licensed, regulated compounding and manufacturing facilities recognized by the relevant national medicines regulatory authority representing the only verifiable, regulated sourcing channel.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every product is sourced from a specifically named, licensed, verifiable supplier.	✗ Sourcing cannot be verified, or "we have a supplier" is the only answer given.
✓ Research-use-only and overseas sourcing are genuinely excluded.	✗ Research-use-only products are used under a different clinical framing.
✓ Certificates of analysis are retained and available for review.	✗ No certificates of analysis or equivalent verification exist.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Primary hormone products are properly sourced, but a newer peptide offering was added without the same verification.**
Sourcing verification needs to apply to every product offered, not only the established ones.

2 **A licensed source is used but certificates of analysis aren't consistently retained.**
A legitimate source doesn't eliminate the value of retaining the actual verification documentation.

3 **Staff know the practice sources responsibly in general but can't name the specific supplier.**
General confidence isn't the same as specific, checkable knowledge.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit every hormone and peptide product currently offered against supplier licensing status.

Week 2 Discontinue or replace any product without a verifiable, licensed source.

Week 3 Establish retained certificate-of-analysis documentation for all products.

Ongoing Verify supplier licensing status periodically, not only at first sourcing.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name the specific supplier for a product currently in use, not describe sourcing generally.
Specificity is the real test of whether sourcing is genuinely verified versus assumed.

Ask directly whether any product offered is sourced as "research use only."
A direct, specific question often surfaces what a general policy question won't.

E-LEARNING academy.gmj.ge/amb-std10-2-product-sourcing — 30 min · complete before self-assessment

Standard 10.3 **NON-NEGOTIABLE** · *Standard 10: Longevity & IV Therapy*

Physician Oversight of Hormone and Peptide Protocols Is Genuine, Not Nominal

ASSESSMENT ASF-AMB-STD10-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

10.3
NON-NEGOTIABLE
L1

THE STANDARD

Physician Oversight of Hormone and Peptide Protocols Is Genuine, Not Nominal

A licensed physician genuinely evaluates and prescribes each patient's specific hormone or peptide protocol, based on that patient's actual results and history — not a standardised protocol applied uniformly with a physician's name attached after the fact.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does a licensed physician genuinely evaluate each patient individually before prescribing a hormone or peptide protocol?** *A real, individual clinical evaluation, not a standard protocol applied to everyone.* Doc: Individual evaluation record	YES	PARTIAL	NO
2	**Is the protocol adjusted based on this specific patient's actual monitoring results, not applied uniformly regardless of results?** *Genuine responsiveness to this patient's data.* Doc: Protocol adjustment record	YES	PARTIAL	NO
3	**Can the physician describe their specific reasoning for a particular patient's protocol?** *Real, individual clinical reasoning, not a general description of the standard approach.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Individual evaluation review*	Reviews records for evidence of genuine, individual patient evaluation before prescribing.
DOCUMENT *Protocol adjustment review*	Reviews whether protocols are adjusted based on individual patient monitoring results.
ASK *Physician reasoning interview*	Asks the physician to describe their specific reasoning for a particular patient's protocol.

REFERENCES

[55] Physician-supervised prescribing, based on individual patient evaluation and monitoring rather than standardised protocols, is identified as the defining distinction between legitimate hormone and peptide therapy and unregulated wellness-market practice.

Standard 10.3 · *Standard 10: Longevity & IV Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD10-v3.0

WHY THIS STANDARD EXISTS

A physician's name on a protocol means little if the actual prescribing decision was never genuinely made by that physician for this specific patient — real oversight requires a real, individualised clinical decision, not administrative sign-off on a template.

The evidence: [55] Physician-supervised prescribing, based on individual patient evaluation and monitoring rather than standardised protocols, is identified as the defining distinction between legitimate hormone and peptide therapy and unregulated wellness-market practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Physician evaluation is genuinely individual, reflected in real, patient-specific documentation.	✗ A standardised protocol is applied to all patients with a physician's name attached.
✓ Protocols are adjusted based on this patient's own monitoring results.	✗ Protocols never change regardless of individual monitoring results.
✓ The physician describes specific, real clinical reasoning for individual cases.	✗ The physician cannot describe specific reasoning beyond a general standard approach.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Initial evaluation is genuinely individual but follow-up adjustments become more standardised over time.**
Ongoing responsiveness to patient data matters as much as the initial evaluation.

2 **Monitoring results are collected but don't consistently change the protocol when they should.**
Data collected but not acted on doesn't provide the protection genuine oversight is meant to offer.

3 **The physician is involved for complex cases but less so for routine ones.**
Every patient's protocol deserves the same genuine individual evaluation, regardless of perceived routine-ness.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of patient protocols for genuine individual evaluation versus standardisation.

Week 2 Establish a consistent process for adjusting protocols based on individual monitoring results.

Week 3 Brief the physician on documenting specific, individual clinical reasoning.

Ongoing Audit protocol individualisation periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Compare two different patients' protocols and documented reasoning.
Genuinely different content reveals real individualisation; near-identical text reveals a standardised template.

Ask the physician to explain a specific protocol decision in detail.
Real clinical reasoning is specific and detailed; a formality reveals itself in vague or general answers.

E-LEARNING academy.gmj.ge/amb-std10-3-physician-oversight — 30 min · complete before self-assessment

	Standard 10.4 **CORE** · *Standard 10: Longevity & IV Therapy* **Baseline Screening Happens Before Any Protocol Begins, Not After**	**ASSESSMENT** ASF-AMB-STD10-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

10.4
CORE
L1

THE STANDARD

Baseline Screening Happens Before Any Protocol Begins, Not After

Every patient undergoes genuine baseline laboratory and clinical screening before a hormone or peptide protocol begins, with monitoring continuing at defined intervals — not a protocol started based on symptoms alone, with testing added only if a problem later emerges.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does every patient undergo genuine baseline screening before any protocol begins, not after starting?** *Testing before the first dose, not added only if a concern later arises.* Doc: Baseline screening record	YES	PARTIAL	NO
2	**Is monitoring continued at defined intervals throughout the protocol, not only at baseline?** *A specific, followed monitoring schedule, not a one-time check.* Doc: Ongoing monitoring schedule	YES	PARTIAL	NO
3	**Are monitoring results actually reviewed and acted on, not just filed?** *Genuine review that can change the protocol, not passive data collection.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Baseline screening review*	Reviews patient records for genuine baseline screening completed before protocol start.
DOCUMENT *Ongoing monitoring schedule review*	Reviews the defined monitoring interval and adherence to it.
ASK *Result review interview*	Asks staff for a real example where a monitoring result changed a protocol decision.

REFERENCES

[56] Baseline laboratory assessment followed by monitoring at defined intervals — for growth hormone secretagogues, typically IGF-1 at baseline, six weeks, and every three to six months thereafter — is identified as a standard safety practice distinct from symptom-triggered testing alone.

Standard 10.4 · *Standard 10: Longevity & IV Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD10-v3.0

WHY THIS STANDARD EXISTS

Starting a hormone or peptide protocol without a genuine baseline means there's no way to know what actually changed, for better or worse, and no way to catch an emerging problem before it becomes serious — monitoring only after symptoms appear is monitoring too late.

The evidence: [56] Baseline laboratory assessment followed by monitoring at defined intervals — for growth hormone secretagogues, typically IGF-1 at baseline, six weeks, and every three to six months thereafter — is identified as a standard safety practice distinct from symptom-triggered testing alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Baseline screening is genuinely completed before every protocol begins.	✗ Protocols begin based on symptoms or patient request, without baseline screening.
✓ Monitoring continues at defined, followed intervals throughout.	✗ No defined ongoing monitoring schedule exists beyond the initial visit.
✓ A real example exists of monitoring results changing a protocol decision.	✗ Monitoring results are collected but never lead to any protocol change.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Baseline screening happens but the specific panel doesn't match what the protocol actually requires.**
Generic baseline testing may miss the specific markers relevant to this particular protocol.

2 **Monitoring intervals are followed initially but lapse as treatment continues.**
Ongoing risk doesn't diminish just because a protocol has been running without incident so far.

3 **Results are reviewed by staff but not consistently by the prescribing physician.**
Genuine clinical review requires the person with prescribing authority to actually see and act on the data.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current screening practice against genuine pre-protocol baseline testing.

Week 2 Establish the specific baseline panel appropriate to each protocol offered.

Week 3 Establish a defined ongoing monitoring interval and physician review process.

Ongoing Audit monitoring adherence and evidence of results genuinely influencing protocol decisions.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real example where a monitoring result changed what was done.
A real example reveals whether monitoring is genuine practice or a formality.

Check whether monitoring intervals are still being followed for patients further along in treatment.
This is where monitoring discipline most commonly erodes over time.

E-LEARNING academy.gmj.ge/amb-std10-4-baseline-screening — 30 min · complete before self-assessment

STANDARD 11

Oncology & Infusion Therapy

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

4 criteria

	Standard 11.1 NON-NEGOTIABLE · *Standard 11: Oncology & Infusion Therapy* **Cytotoxic Drug Handling Follows a Verified Safe-Handling Standard**	ASSESSMENT ASF-AMB-STD11-v3.0
CR N/A	TR FULL	SM FULL	ST FULL

11.1
NON-NEGOTIABLE
L1

THE STANDARD

Cytotoxic Drug Handling Follows a Verified Safe-Handling Standard

Preparation, administration, and disposal of cytotoxic and other hazardous drugs follows a defined, verified safe-handling standard — appropriate personal protective equipment, engineering controls, and disposal procedures — not informal practice that varies by individual staff member.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is appropriate personal protective equipment — including chemotherapy-rated gloves and gowns — used consistently for every stage of handling?** *Consistent use at every stage, not only during administration.* Doc: PPE protocol and observation record	YES	PARTIAL	NO
2	**Are hazardous drugs prepared and stored using the required engineering controls, not standard pharmacy equipment?** *Specific, required controls, not general pharmacy practice assumed to be sufficient.* Doc: Engineering control documentation	YES	PARTIAL	NO
3	**Is hazardous waste disposed of through a defined, compliant pathway, not general medical waste?** *A specific, separate disposal pathway matched to the actual risk.* Doc: Waste disposal record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *PPE and handling observation*	Observes actual handling practice across preparation, administration, and disposal stages.
DOCUMENT *Engineering control review*	Reviews documentation of required engineering controls for hazardous drug preparation and storage.
DOCUMENT *Waste disposal pathway review*	Reviews the defined hazardous waste disposal pathway and compliance records.

REFERENCES

[57] Established hazardous drug handling standards, recognized in various forms across many countries' pharmacy and occupational safety guidance, require defined personal protective equipment, engineering controls, and procedures for the receipt, storage, compounding, administration, and disposal of hazardous drugs.

Standard 11.1 · *Standard 11: Oncology & Infusion Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD11-v3.0

WHY THIS STANDARD EXISTS

Hazardous drug exposure risk extends beyond the patient to every staff member who prepares, administers, or disposes of these medications, and the risks — including reproductive and long-term health effects from repeated exposure — are serious enough that international standards exist specifically to govern every stage of handling, not administration alone.

The evidence: [57] Established hazardous drug handling standards, recognized in various forms across many countries' pharmacy and occupational safety guidance, require defined personal protective equipment, engineering controls, and procedures for the receipt, storage, compounding, administration, and disposal of hazardous drugs.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ PPE is used consistently and correctly at every handling stage.	✗ PPE use is inconsistent or limited to administration only.
✓ Required engineering controls are documented and in place.	✗ Standard pharmacy equipment is used without required hazardous drug controls.
✓ A defined, compliant hazardous waste disposal pathway is followed.	✗ Hazardous waste is disposed of as general medical waste.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **PPE is used correctly during administration but less consistently during preparation.**
Every handling stage carries real exposure risk, not administration alone.

2 **Engineering controls exist but staff weren't specifically trained on their correct use.**
Correct equipment without correct training doesn't provide the intended protection.

3 **Waste disposal follows the correct pathway for most hazardous drugs but not all categories on the hazardous list.**
The full hazardous drug list is broader than chemotherapy alone, and each category carries the same real handling requirement.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current handling practice against required PPE, engineering controls, and disposal standards.

Week 2 Address any gaps in PPE use or engineering controls.

Week 3 Establish or verify a compliant hazardous waste disposal pathway.

Ongoing Train staff periodically and audit handling practice.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe preparation and disposal, not only administration.
Attention often concentrates on administration, leaving earlier and later stages less consistently observed.

Ask to see the actual hazardous waste disposal pathway and its documentation.
A specific, verifiable pathway is the real evidence of compliant disposal.

E-LEARNING academy.gmj.ge/amb-std11-1-hazardous-drug-handling — 30 min · complete before self-assessment

	Standard 11.2 NON-NEGOTIABLE · *Standard 11: Oncology & Infusion Therapy* **Chemotherapy Dose Is Verified by Independent Two-Person Check**	ASSESSMENT ASF-AMB-STD11-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

11.2
NON-NEGOTIABLE
L1

THE STANDARD

Chemotherapy Dose Is Verified by Independent Two-Person Check

Every chemotherapy dose, drug, route, and infusion rate is independently verified by two qualified individuals before administration, each forming their own judgement separately — not a single check followed by a second signature.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every chemotherapy dose undergo independent verification by two qualified individuals before administration?** *Two people, every dose, without exception for perceived routine cases.* Doc: Independent double-check record	YES	PARTIAL	NO
2	**Does each person form their own separate judgement, not simply confirm the first person's check?** *Genuine independence, not sequential confirmation of the same conclusion.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does verification specifically cover drug, dose, route, and infusion rate together, not dose alone?** *All four elements, since an error in any one carries real risk.* Doc: Verification checklist content	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Independent check observation*	Observes an actual double-check for genuine independence between the two verifiers.
DOCUMENT *Verification record review*	Reviews records confirming two-person verification for a sample of recent administrations.
ASK *Verification content interview*	Asks staff what specifically gets verified during the double-check.

REFERENCES

[58] Neuss MN, Gilmore TR, Belderson KM, Billett AL, Conti-Kalchik T, Harvey BE, et al. 2016 Updated American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards, Including Standards for Pediatric Oncology. J Oncol Pract. 2016;12(12):1262-1271 — mandates independent verification by two qualified individuals of chemotherapy drug, dose, route, and infusion rate prior to administration.

Standard 11.2 · *Standard 11: Oncology & Infusion Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD11-v3.0

WHY THIS STANDARD EXISTS

Chemotherapy dosing errors carry genuinely serious consequences, and a single point of verification means a single point of failure — the independent double-check exists specifically because two people forming separate judgements catch errors that one person, however careful, can miss.

The evidence: [58] Neuss MN, Gilmore TR, Belderson KM, Billett AL, Conti-Kalchik T, Harvey BE, et al. 2016 Updated American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards, Including Standards for Pediatric Oncology. J Oncol Pract. 2016;12(12):1262-1271 — mandates independent verification by two qualified individuals of chemotherapy drug, dose, route, and infusion rate prior to administration.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every dose undergoes genuine, independent two-person verification.	✗ Verification happens for some doses but not consistently for all.
✓ Each verifier forms their own separate judgement.	✗ The second check simply confirms the first person's conclusion.
✓ Verification covers drug, dose, route, and infusion rate together.	✗ Verification covers dose alone, missing route or infusion rate.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Independent verification is strong for new regimens but becomes routine and less rigorous for familiar ones.**
Familiarity can quietly erode the genuine independence the check depends on.

2 **Verification happens together, side by side, rather than separately before comparing.**
Checking together risks one person's read of the order influencing the other's, undermining genuine independence.

3 **Infusion rate verification is inconsistent compared to drug and dose verification.**
An incorrect rate carries real risk distinct from an incorrect dose or drug.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current verification practice for genuine independence between checkers.

Week 2 Retrain staff on separate, independent verification before comparing conclusions.

Week 3 Confirm the verification checklist covers drug, dose, route, and infusion rate together.

Ongoing Audit verification records and observe practice periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual double-check, watching specifically for separate, independent review.
Genuine independence is visible in practice in a way records alone cannot confirm.

Ask two different verifiers separately what they checked.
Consistent, specific answers from both reveal genuine independent verification.

E-LEARNING academy.gmj.ge/amb-std11-2-dose-verification — 30 min · complete before self-assessment

	Standard 11.3 **NON-NEGOTIABLE** · *Standard 11: Oncology & Infusion Therapy* **Extravasation Is Recognised and Managed Immediately**	**ASSESSMENT** ASF-AMB-STD11-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

11.3
NON-NEGOTIABLE
L1

THE STANDARD

Extravasation Is Recognised and Managed Immediately

Staff administering vesicant or irritant chemotherapy agents are specifically trained to recognise early signs of extravasation, with a defined, immediate management protocol and appropriate antidotes genuinely available on-site.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are staff specifically trained to recognise early signs of extravasation for the agents actually used here?** *Specific to the actual agents administered, not generic infusion complication awareness.* Doc: Extravasation recognition training record	YES	PARTIAL	NO
2	**Is there a defined, immediate management protocol for suspected extravasation?** *A specific, known protocol, not improvisation in the moment.* Doc: Extravasation management protocol	YES	PARTIAL	NO
3	**Are appropriate antidotes for the specific vesicant agents used genuinely available on-site?** *Immediately available and in date, matched to the actual agents in use.* Doc: On-site antidote stock record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Recognition training review*	Reviews training records for extravasation recognition specific to agents actually used.
DOCUMENT *Management protocol review*	Reviews the defined immediate management protocol for completeness.
OBSERVE *Antidote stock check*	Physically confirms appropriate antidotes are on-site, matched to agents used, and in date.

REFERENCES

[59] Extravasation recognition and immediate management protocols, including agent-specific antidote availability, are established as a distinct and essential component of safe chemotherapy administration, separate from general infusion site monitoring.

Standard 11.3 · *Standard 11: Oncology & Infusion Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD11-v3.0

WHY THIS STANDARD EXISTS

Extravasation of a vesicant chemotherapy agent can cause severe, sometimes permanent tissue damage, and the difference between a manageable event and lasting harm often comes down to how quickly it's recognised and correctly managed, not the event itself.

The evidence: [59] Extravasation recognition and immediate management protocols, including agent-specific antidote availability, are established as a distinct and essential component of safe chemotherapy administration, separate from general infusion site monitoring.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff are specifically trained on extravasation recognition for the actual agents used.	✗ Training is generic, not specific to the agents actually administered.
✓ A defined, immediate management protocol exists.	✗ No defined protocol exists beyond general awareness that extravasation can occur.
✓ Appropriate antidotes are genuinely on-site and in date.	✗ Antidotes aren't on-site or are expired.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Recognition training happened at hiring but hasn't been refreshed as new agents were introduced.**
Training needs to stay current with the actual agents in use, not reflect an earlier point in time.

2 **A protocol exists but doesn't specify agent-specific management steps.**
Different vesicant agents may require different specific management approaches.

3 **Antidote stock exists but expiry dates weren't recently verified.**
Expired antidotes provide no real protection when actually needed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current extravasation training against the specific agents administered.

Week 2 Update or establish an agent-specific management protocol.

Week 3 Confirm on-site antidote stock and expiry dates for all vesicant agents used.

Ongoing Refresh training whenever new agents are introduced.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about a specific agent used here, not extravasation in general.
Specificity reveals whether training genuinely reflects current practice.

Physically check antidote stock and expiry dates.
Physical verification is the only real evidence of genuine on-site availability.

E-LEARNING academy.gmj.ge/amb-std11-3-extravasation — 30 min · complete before self-assessment

	Standard 11.4 NON-NEGOTIABLE · *Standard 11: Oncology & Infusion Therapy* **Infusion Reaction and Anaphylaxis Response Is Rehearsed, Not Theoretical**	ASSESSMENT ASF-AMB-STD11-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

11.4
NON-NEGOTIABLE
L1

THE STANDARD

Infusion Reaction and Anaphylaxis Response Is Rehearsed, Not Theoretical

Staff are trained and drilled — not only briefed — on recognising and responding to infusion reactions and anaphylaxis, with emergency medications and equipment genuinely available at the point of infusion, verified through a real, practiced response, not a written plan alone.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Have staff actually rehearsed an infusion reaction and anaphylaxis response, not only reviewed a written protocol?** *A genuine drill, not a policy document read once.* Doc: Drill record, date and participants	YES	PARTIAL	NO
2	**Are emergency medications and equipment genuinely available at the point of infusion, not in a separate location requiring retrieval?** *Immediately at hand, not requiring travel to another room during an emergency.* Doc: Emergency equipment location and stock record	YES	PARTIAL	NO
3	**Do all staff present during infusions know their specific role in a reaction response, not just that a protocol exists?** *Specific, assigned roles, not general awareness.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Drill record review*	Reviews records of actual rehearsed drills, not only protocol review sessions.
OBSERVE *Emergency equipment location check*	Confirms emergency medications and equipment are genuinely at the point of infusion.
ASK *Role assignment interview*	Asks staff present during infusions to describe their specific role in a reaction response.

REFERENCES

[60] Infusion reaction and anaphylaxis response protocols, including rehearsed drills rather than written policy alone, are identified as essential to safe ambulatory infusion practice given the narrow time window in which effective intervention determines patient outcome.

Standard 11.4 · *Standard 11: Oncology & Infusion Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD11-v3.0

WHY THIS STANDARD EXISTS

An infusion reaction can escalate to anaphylaxis within minutes, and a written protocol nobody has actually practiced is a poor substitute for a team that has rehearsed the actual sequence of what to do, in the actual space where infusions happen.

The evidence: [60] Infusion reaction and anaphylaxis response protocols, including rehearsed drills rather than written policy alone, are identified as essential to safe ambulatory infusion practice given the narrow time window in which effective intervention determines patient outcome.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff have genuinely rehearsed the response, with dated drill records.	✗ Only written protocol review has occurred, with no actual drill.
✓ Emergency medications and equipment are immediately available at the point of infusion.	✗ Emergency equipment requires retrieval from another location.
✓ Staff can describe their specific, assigned role in a response.	✗ Staff are aware a protocol exists but can't describe their specific role.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A drill was conducted once but hasn't been repeated since.**
Rehearsed response capability fades over time without periodic repetition, particularly given staff turnover.

2 **Emergency equipment is nearby but not genuinely at every point where infusions actually happen.**
A reaction can occur at any infusion chair, and equipment needs to be immediately reachable from all of them.

3 **Clinical staff know their role clearly but support staff present during infusions are less certain.**
A reaction response often benefits from every present staff member knowing their part, not clinical staff alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Assess current response readiness against genuine rehearsed practice, not policy review alone.

Week 2 Conduct an actual reaction response drill with all relevant staff.

Week 3 Verify emergency equipment is genuinely accessible from every infusion point.

Ongoing Repeat drills periodically, particularly after staff changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the date of the last actual drill, not the date the protocol was written.
A specific, recent drill date is the real evidence of rehearsed readiness.

Ask a support staff member, not just a nurse, about their role in a response.
This reveals whether readiness genuinely extends to everyone present, not only clinical staff.

E-LEARNING academy.gmj.ge/amb-std11-4-infusion-reaction — 30 min · complete before self-assessment

STANDARD 12

Dialysis & Renal Replacement Therapy

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

4 criteria

	Standard 12.1 **NON-NEGOTIABLE** · *Standard 12: Dialysis & Renal Replacement Therapy* **Dialysis Water Treatment Meets a Verified Quality Standard**	**ASSESSMENT** ASF-AMB-STD12-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

12.1
NON-NEGOTIABLE
L1

THE STANDARD

Dialysis Water Treatment Meets a Verified Quality Standard

Water used to prepare dialysis fluid meets defined chemical and microbiological quality requirements, verified through regular testing against a recognised international standard — not assumed safe because it passes through a treatment system.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is dialysis water tested against the specific chemical and microbiological limits set by the recognised standard, not general water safety limits?** *Dialysis-specific limits, which are meaningfully stricter than general drinking water standards.* Doc: Water quality testing record against ISO 23500-3 limits	YES	PARTIAL	NO
2	**Is testing conducted on a defined, regular schedule, with results reviewed and acted on?** *Regular, scheduled testing with genuine review, not occasional or reactive testing.* Doc: Testing schedule and review record	YES	PARTIAL	NO
3	**Is there a defined response if a test result exceeds the allowable limit?** *A specific action, not uncertainty about what happens when a limit is exceeded.* Doc: Out-of-limit response protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Water quality testing review*	Reviews testing records against the specific ISO 23500-3 chemical and microbiological limits.
DOCUMENT *Testing schedule review*	Reviews the testing schedule for consistency and genuine review of results.
ASK *Out-of-limit response interview*	Asks staff what happens when a water quality result exceeds the allowable limit.

REFERENCES

[61] International Organization for Standardization. ISO 23500-3:2024 — Preparation and quality management of fluids for haemodialysis and related therapies — Part 3: Water for haemodialysis and related therapies. Geneva: ISO; 2024 — specifies minimum chemical and microbiological quality requirements for dialysis water, with mandatory ongoing monitoring.

Standard 12.1 · *Standard 12: Dialysis & Renal Replacement Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD12-v3.0

WHY THIS STANDARD EXISTS

Dialysis water enters the patient's bloodstream indirectly through the dialysis fluid, at volumes far exceeding typical water exposure — contamination that would be harmless in drinking water can be genuinely dangerous here, which is why this has its own dedicated international standard distinct from general water safety.

The evidence: [61] International Organization for Standardization. ISO 23500-3:2024 — Preparation and quality management of fluids for haemodialysis and related therapies — Part 3: Water for haemodialysis and related therapies. Geneva: ISO; 2024 — specifies minimum chemical and microbiological quality requirements for dialysis water, with mandatory ongoing monitoring.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Water is tested against the specific dialysis water quality standard consistently.	✗ Testing, if it happens, isn't matched against dialysis-specific limits.
✓ Testing happens on a defined, regular schedule with genuine review.	✗ Testing is occasional or reactive rather than scheduled.
✓ A specific, followed response exists for any out-of-limit result.	✗ No defined response exists for an out-of-limit result.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Chemical testing happens consistently but microbiological testing lapses periodically.**
Both chemical and microbiological contamination carry genuine, distinct risk.

2 **Testing happens on schedule but results aren't reviewed by anyone with authority to act on them.**
Testing without genuine review provides limited real protection.

3 **A response protocol exists but hasn't actually been used or tested.**
An untested protocol may not translate smoothly into real action when actually needed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current water testing practice against the specific dialysis water quality standard.

Week 2 Establish or correct a defined, regular testing schedule.

Week 3 Define a specific response protocol for out-of-limit results.

Ongoing Review testing consistency and result trends periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for actual test results against the specific numeric limits, not a general assurance of water safety.
Dated, specific records are the only real evidence of genuine compliance.

Ask what happened the last time a result was concerning.
A real example reveals more than a policy description.

E-LEARNING academy.gmj.ge/amb-std12-1-water-quality — 30 min · complete before self-assessment

	Standard 12.2 NON-NEGOTIABLE · *Standard 12: Dialysis & Renal Replacement Therapy* **Vascular Access Site Care Follows Recognised Core Interventions**	ASSESSMENT ASF-AMB-STD12-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

12.2
NON-NEGOTIABLE
L1

THE STANDARD

Vascular Access Site Care Follows Recognised Core Interventions

Vascular access care and catheter accessing follow a defined set of core infection prevention interventions — aseptic technique, hub disinfection, and structured surveillance — verified through periodic direct observation, not assumed from staff training alone.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are the specific core interventions — surveillance, hand hygiene observation, vascular access care observation — all actively followed, not only some of them?** *All core interventions together, not a partial selection.* Doc: Core intervention implementation record	YES	PARTIAL	NO
2	**Is vascular access care and catheter accessing technique directly observed on a defined schedule, not assumed from training?** *Direct observation, at least quarterly, not reliance on initial training alone.* Doc: Direct observation record	YES	PARTIAL	NO
3	**Is infection surveillance data calculated and actively shared with front-line clinical staff, not filed without review?** *Genuine sharing that could influence practice, not passive record-keeping.* Doc: Surveillance data sharing record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Core intervention implementation review*	Reviews evidence that all core interventions are actively implemented, not a partial selection.
DOCUMENT *Direct observation record review*	Reviews records of direct vascular access care observation against the recommended schedule.
ASK *Data sharing interview*	Asks front-line staff whether they've seen recent infection surveillance data for this facility.

REFERENCES

[62] Established infection prevention guidance for dialysis settings, recognized in various forms internationally, recommends monthly infection surveillance, regular hand hygiene observation, and quarterly direct observation of vascular access care and catheter accessing technique.

Standard 12.2 · *Standard 12: Dialysis & Renal Replacement Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD12-v3.0

WHY THIS STANDARD EXISTS

Bloodstream infection is a serious, well-documented risk specific to dialysis vascular access, and international surveillance data shows real, measurable reduction in infection rates where these specific interventions are consistently followed and actively observed, not just trained once.

The evidence: [62] Established infection prevention guidance for dialysis settings, recognized in various forms internationally, recommends monthly infection surveillance, regular hand hygiene observation, and quarterly direct observation of vascular access care and catheter accessing technique.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ All core interventions are actively implemented together.	✗ Only some core interventions are followed, with others informally skipped.
✓ Direct observation of vascular access care happens on the recommended schedule.	✗ No direct observation happens beyond initial staff training.
✓ Surveillance data is genuinely shared with and visible to front-line staff.	✗ Surveillance data, if collected, isn't shared with clinical staff.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Hand hygiene observation happens consistently but vascular access observation is less regular.**
Each core intervention addresses a distinct part of the same real infection risk.

2 **Observation happens but findings aren't fed back to the specific staff observed.**
Observation without feedback provides less real improvement than genuine feedback.

3 **Surveillance data is calculated but shared only with management, not front-line staff.**
Front-line staff acting on the data day to day benefit most directly from seeing it.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice against the full set of core interventions.

Week 2 Establish or correct a quarterly direct observation schedule for vascular access care.

Week 3 Establish a process for actively sharing surveillance data with front-line staff.

Ongoing Track infection rates and adjust practice based on trends.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for actual observation records, not a description of the training staff received.
Dated observation records are the real evidence of ongoing verification, not one-time training.

Ask a front-line staff member whether they've seen recent infection rate data for this facility.
This reveals whether data sharing is genuine practice, not just collected and filed.

E-LEARNING academy.gmj.ge/amb-std12-2-vascular-access-care — 30 min · complete before self-assessment

	Standard 12.3 NON-NEGOTIABLE · *Standard 12: Dialysis & Renal Replacement Therapy* **Patients Are Monitored for Intradialytic Complications Throughout**	ASSESSMENT ASF-AMB-STD12-v3.0
CR N/A	TR FULL	SM FULL	ST FULL

12.3
NON-NEGOTIABLE
L1

THE STANDARD

Patients Are Monitored for Intradialytic Complications Throughout

Patients are actively monitored throughout the dialysis session for signs of intradialytic complications — hypotension, cramping, access-related bleeding — on a defined schedule, not checked only at the start and end of the session.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are patients monitored at defined intervals throughout the entire session, not only at start and end?** *Monitoring spread across the full session duration, not concentrated at the edges.* Doc: Intradialytic monitoring schedule and record	YES	PARTIAL	NO
2	**Does monitoring specifically include blood pressure, access site, and patient-reported symptoms together?** *All three together, since each can reveal a different type of developing complication.* Doc: Monitoring content documentation	YES	PARTIAL	NO
3	**Is there a defined, immediate response if monitoring identifies a possible complication?** *A specific, known response, not improvisation in the moment.* Doc: Complication response protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Intradialytic monitoring observation*	Observes actual monitoring practice during a dialysis session for consistency throughout.
DOCUMENT *Monitoring content review*	Reviews whether monitoring covers blood pressure, access site, and symptoms together.
ASK *Complication response interview*	Asks staff what happens when monitoring identifies a possible complication.

REFERENCES

[63] Structured intradialytic monitoring at defined intervals throughout the dialysis session, rather than only at session start and end, is established practice in dialysis safety literature for early detection of hypotension and other acute complications.

Standard 12.3 · *Standard 12: Dialysis & Renal Replacement Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD12-v3.0

WHY THIS STANDARD EXISTS

A multi-hour dialysis session carries real risk of complications developing partway through, and monitoring concentrated only at the beginning and end of the session can miss a problem during exactly the hours it's most likely to actually occur.

The evidence: [63] Structured intradialytic monitoring at defined intervals throughout the dialysis session, rather than only at session start and end, is established practice in dialysis safety literature for early detection of hypotension and other acute complications.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Monitoring happens at defined intervals throughout the entire session.	✗ Monitoring is concentrated at session start and end, with gaps during the session.
✓ Monitoring covers blood pressure, access site, and symptoms together.	✗ Monitoring covers only one element, such as blood pressure, without the others.
✓ A specific, immediate response protocol exists and is known to staff.	✗ Staff are uncertain what to do if a complication is identified mid-session.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Monitoring is thorough during quiet periods but abbreviated when the unit is busy.**
Complications don't occur only when staff have time available to notice them.

2 **Blood pressure is checked regularly but access site and symptom checks are less consistent.**
Each element of monitoring reveals a genuinely different type of developing complication.

3 **A response protocol exists for hypotension specifically but not other complication types.**
Multiple distinct complication types can develop during a session, each warranting a defined response.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current monitoring practice for consistency throughout actual sessions.

Week 2 Establish a defined monitoring interval covering the full session duration.

Week 3 Ensure monitoring content covers blood pressure, access site, and symptoms together.

Ongoing Observe monitoring practice periodically, particularly during busy periods.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe during a genuinely busy period, not a quiet one.
Monitoring discipline is most likely to erode exactly when the unit is under real pressure.

Ask about a specific complication type beyond hypotension, such as access-related bleeding.
This reveals whether response readiness extends beyond the most commonly discussed complication.

E-LEARNING academy.gmj.ge/amb-std12-3-intradialytic-monitoring — 30 min · complete before self-assessment

	Standard 12.4 **NON-NEGOTIABLE** · *Standard 12: Dialysis & Renal Replacement Therapy* **Reuse or Single-Use Policy for Dialyzers Is Explicit and Followed**	**ASSESSMENT** ASF-AMB-STD12-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

12.4
NON-NEGOTIABLE
L1

THE STANDARD

Reuse or Single-Use Policy for Dialyzers Is Explicit and Followed

The facility has an explicit, written policy on whether dialyzers are single-use or reprocessed for reuse, with the actual practice matching the written policy, and any reprocessing following a defined, verified protocol — not an informal practice that varies without a stated policy.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the facility have an explicit, written policy stating whether dialyzers are single-use or reprocessed?** *A specific, written policy, not an informal, undocumented practice.* Doc: Written reuse policy document	YES	PARTIAL	NO
2	**Does actual practice match the written policy, verified directly, not assumed?** *Genuine consistency between stated policy and real practice.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Where reprocessing occurs, does it follow a defined, verified protocol, including water quality specific to reprocessing?** *A specific, verified protocol, not informal reprocessing practice.* Doc: Reprocessing protocol and verification record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Written policy review*	Reviews the facility's explicit, written reuse or single-use policy.
OBSERVE *Practice-policy consistency check*	Checks whether actual practice matches the written policy.
DOCUMENT *Reprocessing protocol review*	Where reprocessing occurs, reviews the defined protocol and water quality verification specific to reprocessing.

REFERENCES

[64] International Organization for Standardization. ISO 23500-1:2024 — Preparation and quality management of fluids for haemodialysis and related therapies — Part 1: General requirements. Geneva: ISO; 2024 — addresses water used in dialyser reprocessing as a distinct, covered aspect of dialysis fluid quality management.

Standard 12.4 · *Standard 12: Dialysis & Renal Replacement Therapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD12-v3.0

WHY THIS STANDARD EXISTS

Whether a facility reuses dialyzers is a real, significant infection-control decision with international variation in practice, and the risk isn't in which approach a facility chooses, but in practice quietly diverging from what's actually documented, tracked, and verified.

The evidence: [64] International Organization for Standardization. ISO 23500-1:2024 — Preparation and quality management of fluids for haemodialysis and related therapies — Part 1: General requirements. Geneva: ISO; 2024 — addresses water used in dialyser reprocessing as a distinct, covered aspect of dialysis fluid quality management.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ An explicit, written policy exists and is clear.	✗ No written policy exists, only informal, undocumented practice.
✓ Actual practice consistently matches the written policy.	✗ Practice diverges from what's actually written in the policy.
✓ Any reprocessing follows a defined, verified protocol.	✗ Reprocessing, if it occurs, has no defined or verified protocol.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A policy exists but hasn't been updated to reflect a practice change made some time ago.**
A stale policy no longer reflects genuine current practice, creating exactly the mismatch this criterion checks for.

2 **Practice matches policy for most patients but exceptions are made informally without documentation.**
Undocumented exceptions undermine the reliability of the stated policy.

3 **Reprocessing follows a protocol but water quality verification specific to reprocessing wasn't recently checked.**
Reprocessing water carries the same real quality requirements as water used for treatment itself.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Confirm current actual practice and compare against any existing written policy.

Week 2 Write or update the policy to genuinely reflect current practice.

Week 3 If reprocessing occurs, verify the protocol and water quality requirements specific to it.

Ongoing Periodically confirm practice continues to match the written policy.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual written policy, not a verbal description of practice.
A specific, written document is the real evidence of an explicit policy.

Ask a front-line staff member to describe current practice, and compare it against the written policy.
This reveals whether policy and practice genuinely align, or have quietly diverged.

E-LEARNING academy.gmj.ge/amb-std12-4-dialyzer-reuse-policy — 30 min · complete before self-assessment

STANDARD 13

Fertility & IVF

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

5 criteria

Standard 13.1 **NON-NEGOTIABLE** · *Standard 13: Fertility & IVF*

Embryology Lab Quality Control Is Verified, Not Assumed

ASSESSMENT ASF-AMB-STD13-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

13.1
NON-NEGOTIABLE
L1

THE STANDARD

Embryology Lab Quality Control Is Verified, Not Assumed

Embryo and oocyte assessment follows a recognised international consensus standard, with laboratory conditions — temperature, air quality, incubator calibration — verified through defined, regular quality control, not assumed stable because equipment appears to be functioning.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does embryo and oocyte assessment follow a recognised international consensus standard, applied consistently?** *A named, recognised standard, applied by every embryologist consistently.* Doc: Assessment protocol documentation	YES	PARTIAL	NO
2	**Are laboratory conditions — temperature, air quality, incubator calibration — verified through defined, regular quality control?** *Regular, scheduled verification, not assumed from equipment appearing to function.* Doc: Laboratory quality control log	YES	PARTIAL	NO
3	**Is there a defined response if quality control identifies conditions outside acceptable range?** *A specific action, not uncertainty about what happens when a reading is out of range.* Doc: Out-of-range response protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Assessment standard review*	Reviews assessment protocols against the recognised international consensus standard.
DOCUMENT *Quality control log review*	Reviews laboratory condition quality control logs for consistency and regularity.
ASK *Out-of-range response interview*	Asks laboratory staff what happens when a quality control reading is outside acceptable range.

REFERENCES

[65] Alpha Scientists in Reproductive Medicine, ESHRE Special Interest Group of Embryology. The Istanbul consensus update: a revised ESHRE/ALPHA consensus on oocyte and embryo static and dynamic morphological assessment. Hum Reprod. 2025 — establishes internationally recognised, evidence-based criteria for oocyte and embryo assessment.

Standard 13.1 · *Standard 13: Fertility & IVF*

Guidance & Learning

GUIDANCE ASF-AMB-STD13-v3.0

WHY THIS STANDARD EXISTS

Embryo development is genuinely sensitive to laboratory conditions, and a subtle, undetected drift in temperature or air quality can affect outcomes without any visible sign until results are reviewed much later — regular, defined quality control is what catches this before it affects patients.

The evidence: [65] Alpha Scientists in Reproductive Medicine, ESHRE Special Interest Group of Embryology. The Istanbul consensus update: a revised ESHRE/ALPHA consensus on oocyte and embryo static and dynamic morphological assessment. Hum Reprod. 2025 — establishes internationally recognised, evidence-based criteria for oocyte and embryo assessment.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Assessment consistently follows the recognised international standard.	✗ Assessment practice varies by individual embryologist without a consistent standard.
✓ Laboratory conditions are verified through defined, regular quality control.	✗ Laboratory conditions are assumed stable without regular verification.
✓ A specific, followed response exists for any out-of-range reading.	✗ No defined response exists for an out-of-range reading.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Temperature is monitored consistently but air quality checks are less regular.**
Each laboratory condition can independently affect embryo development.

2 **Quality control happens but results aren't reviewed by someone with authority to act on them.**
Monitoring without genuine review provides limited real protection.

3 **The assessment standard is followed for routine cases but applied less consistently for complex ones.**
Complex cases carry at least the same real stakes as routine ones.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current assessment practice against the recognised international standard.

Week 2 Establish or verify a defined, regular laboratory quality control schedule.

Week 3 Define a specific response protocol for out-of-range conditions.

Ongoing Review quality control logs and assessment consistency periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for actual quality control logs, not a general assurance conditions are stable.
Dated, specific records are the only real evidence of consistent verification.

Ask two different embryologists to assess the same case criteria.
Consistent answers reveal genuine standardisation; differing answers reveal informal, individual practice.

E-LEARNING academy.gmj.ge/amb-std13-1-embryology-quality — 30 min · complete before self-assessment

Standard 13.2 **NON-NEGOTIABLE** · *Standard 13: Fertility & IVF*

Hormone Stimulation Protocols Have Real, Documented Physician Oversight

ASSESSMENT ASF-AMB-STD13-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

13.2
NON-NEGOTIABLE
L1

THE STANDARD

Hormone Stimulation Protocols Have Real, Documented Physician Oversight

Ovarian stimulation protocols are individually determined and monitored by a licensed physician based on this specific patient's response, following recognised clinical guidance — not a standardised protocol applied uniformly regardless of individual monitoring results.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is the stimulation protocol individually determined for this specific patient, not a standard protocol applied uniformly?** *A real, individual clinical decision, reflecting this patient's own profile.* Doc: Individual protocol determination record	YES	PARTIAL	NO
2	**Is the protocol adjusted based on this patient's actual monitoring results during stimulation?** *Genuine responsiveness to real-time monitoring data, not a fixed plan followed regardless.* Doc: Protocol adjustment record	YES	PARTIAL	NO
3	**Is there a defined process for recognising and managing ovarian hyperstimulation syndrome risk specifically?** *A specific, known process for this specific serious risk, not general awareness alone.* Doc: OHSS risk management protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Individual protocol review*	Reviews records for evidence of genuine, individual protocol determination.
DOCUMENT *Adjustment record review*	Reviews whether protocols are adjusted based on individual monitoring results during stimulation.
ASK *OHSS management interview*	Asks the physician to describe the specific process for recognising and managing OHSS risk.

REFERENCES

[66] European Society of Human Reproduction and Embryology. ESHRE guideline: ovarian stimulation for IVF/ICSI — an update. Hum Reprod. 2025 — establishes individualised, response-based protocol adjustment as core to safe ovarian stimulation practice.

Standard 13.2 · *Standard 13: Fertility & IVF*
Guidance & Learning

GUIDANCE ASF-AMB-STD13-v3.0

WHY THIS STANDARD EXISTS

Ovarian stimulation carries real, serious risk — including ovarian hyperstimulation syndrome — that genuinely depends on individual patient response, and a protocol that doesn't adjust to that response isn't providing the protection real physician oversight is meant to offer.

The evidence: [66] European Society of Human Reproduction and Embryology. ESHRE guideline: ovarian stimulation for IVF/ICSI — an update. Hum Reprod. 2025 — establishes individualised, response-based protocol adjustment as core to safe ovarian stimulation practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Protocols are genuinely individualised, reflected in real, patient-specific documentation.	✗ A standardised protocol is applied uniformly regardless of individual patient profile.
✓ Protocols are adjusted based on this patient's own monitoring results.	✗ Protocols don't change despite individual monitoring results suggesting they should.
✓ A specific, known OHSS recognition and management process exists.	✗ No specific process exists for OHSS risk beyond general awareness.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Initial protocol determination is individualised but adjustments during stimulation become more standardised.**
Ongoing responsiveness to monitoring matters as much as the initial individualised decision.

2 **Monitoring happens but isn't consistently reviewed by the physician in time to adjust the protocol meaningfully.**
Delayed review limits the ability to actually respond to what monitoring reveals.

3 **OHSS risk is recognised for high-risk patients but the process isn't consistently applied to lower apparent risk.**
Risk assessment itself can be wrong; a consistent process protects against that possibility.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of stimulation protocols for genuine individual determination.

Week 2 Establish a consistent process for adjusting protocols based on real-time monitoring.

Week 3 Define and brief staff on a specific OHSS recognition and management process.

Ongoing Audit protocol individualisation and OHSS management readiness periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Compare two different patients' protocols and documented reasoning.
Genuinely different content reveals real individualisation; near-identical protocols reveal standardisation.

Ask the physician to describe a specific OHSS case, real or hypothetical, in detail.
Specific, detailed knowledge reveals genuine readiness rather than general awareness.

E-LEARNING academy.gmj.ge/amb-std13-2-stimulation-oversight — 30 min · complete before self-assessment

Standard 13.3 **CORE** · *Standard 13: Fertility & IVF*

Multiple-Pregnancy Risk Is Explicitly Discussed Before Transfer

ASSESSMENT ASF-AMB-STD13-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

13.3
CORE
L1

THE STANDARD

Multiple-Pregnancy Risk Is Explicitly Discussed Before Transfer

Before every embryo transfer, the patient has a genuine, documented conversation about multiple-pregnancy risk specific to the number of embryos being considered, including the option of single embryo transfer — not a generic consent form covering "embryo transfer" without this specific discussion.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every patient have a specific, documented conversation about multiple-pregnancy risk before transfer?** *A specific conversation about this risk, not folded into general transfer consent.* Doc: Multiple-pregnancy risk discussion documentation	YES	PARTIAL	NO
2	**Is single embryo transfer genuinely presented as an option, not just multiple-embryo transfer as the default?** *A genuine choice presented, not a default the patient would need to actively push back against.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Can the patient explain back the specific risk relevant to their own transfer decision?** *Tests genuine understanding, not just that a conversation occurred.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Risk discussion documentation review*	Reviews records for a specific, documented multiple-pregnancy risk discussion distinct from general consent.
OBSERVE *Transfer consultation observation*	Observes an actual pre-transfer consultation for genuine discussion of single embryo transfer as an option.
ASK *Patient understanding check*	Asks a patient to explain back the specific risk relevant to their own transfer decision.

REFERENCES

[67] Single embryo transfer, with explicit discussion of multiple-pregnancy risk as part of the transfer decision, is established international guidance for reducing avoidable multiple-pregnancy risk in IVF, distinct from general transfer procedure consent.

Standard 13.3 · *Standard 13: Fertility & IVF*

Guidance & Learning

GUIDANCE ASF-AMB-STD13-v3.0

WHY THIS STANDARD EXISTS

Multiple pregnancy carries real, elevated risk to both the pregnant patient and the babies, and this is a risk patients can genuinely weigh and choose about — but only if the conversation actually happens specifically, not folded into general transfer consent.

The evidence: [67] Single embryo transfer, with explicit discussion of multiple-pregnancy risk as part of the transfer decision, is established international guidance for reducing avoidable multiple-pregnancy risk in IVF, distinct from general transfer procedure consent.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every patient has a specific, documented multiple-pregnancy risk conversation.	✗ Multiple-pregnancy risk is folded into general consent without specific discussion.
✓ Single embryo transfer is genuinely presented as a real option.	✗ Multiple-embryo transfer is presented as the default with no genuine alternative offered.
✓ Patients can explain back the risk relevant to their own decision.	✗ Patients cannot describe the specific risk relevant to their transfer.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The discussion happens for patients considering multiple-embryo transfer but not those already planning single transfer.**
Even a patient inclined toward single transfer benefits from understanding why the choice matters.

2 **Risk is mentioned but single embryo transfer isn't genuinely presented as an equally valid option.**
A mentioned risk without a genuine alternative doesn't provide a real choice.

3 **The conversation happens once, early in treatment, and isn't revisited at the actual point of transfer decision.**
Circumstances and patient thinking can genuinely change by the time transfer is actually being decided.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current pre-transfer consent practice for specific multiple-pregnancy risk discussion.

Week 2 Build a specific discussion point into the pre-transfer consultation, distinct from general consent.

Week 3 Train staff to genuinely present single embryo transfer as a real option.

Ongoing Spot-check patient understanding after pre-transfer consultations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the patient, not the clinician, to describe the risk discussion they had.
This tests actual understanding, not staff confidence in their own explanation.

Ask specifically whether single embryo transfer was presented as a genuine option.
A direct question often reveals what a general consent review won't.

E-LEARNING academy.gmj.ge/amb-std13-3-multiple-pregnancy-risk — 30 min · complete before self-assessment

Standard 13.4 **CORE** · *Standard 13: Fertility & IVF*

High-Stakes Consent Reflects the Real Emotional and Financial Weight of the Decision

ASSESSMENT ASF-AMB-STD13-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

13.4
CORE
L1

THE STANDARD

High-Stakes Consent Reflects the Real Emotional and Financial Weight of the Decision

Consent conversations for fertility treatment genuinely address the real emotional and financial weight of the decision — realistic success rates specific to this patient, not generic clinic statistics, and the real possibility of an unsuccessful cycle — not a form focused only on the physical procedure.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does consent include realistic success rates specific to this patient's own profile, not generic clinic-wide statistics?** *Individualised, honest expectations, not marketing-oriented general figures.* Doc: Individualised success rate discussion documentation	YES	PARTIAL	NO
2	**Is the real possibility of an unsuccessful cycle genuinely discussed, not treated as an unlikely exception?** *Honest acknowledgement, not an implicit assumption of success.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the conversation address the real financial commitment, including the possibility of multiple cycles?** *Genuine financial transparency, not deferred until costs are already being incurred.* Doc: Financial discussion documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Individualised success rate review*	Reviews consent documentation for patient-specific, not generic, success rate discussion.
OBSERVE *Consent conversation observation*	Observes an actual consent conversation for genuine discussion of unsuccessful-cycle possibility.
ASK *Financial discussion interview*	Asks a patient whether the real financial commitment, including possible multiple cycles, was discussed upfront.

REFERENCES

[68] Realistic, individualised success rate discussion, distinct from generic clinic-wide statistics, is identified as an essential component of genuinely informed consent in fertility treatment, given the significant emotional and financial stakes involved.

Standard 13.4 · *Standard 13: Fertility & IVF*

Guidance & Learning

GUIDANCE ASF-AMB-STD13-v3.0

WHY THIS STANDARD EXISTS

Fertility treatment carries a weight most medical consent doesn't — genuine emotional investment and real financial cost, often across multiple attempted cycles — and a consent process that addresses only the physical procedure while treating success as assumed doesn't reflect what the patient is actually deciding.

The evidence: [68] Realistic, individualised success rate discussion, distinct from generic clinic-wide statistics, is identified as an essential component of genuinely informed consent in fertility treatment, given the significant emotional and financial stakes involved.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Success rates discussed are specific to this patient, not generic clinic statistics.	✗ Success rates cited are generic clinic marketing figures, not individualised.
✓ The real possibility of an unsuccessful cycle is genuinely, honestly discussed.	✗ Consent implicitly assumes success, without genuine discussion of failure possibility.
✓ Financial commitment, including possible multiple cycles, is discussed upfront.	✗ Financial discussion happens only as costs are being incurred, not upfront.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Individualised success rates are discussed for the first cycle but not revisited for subsequent attempts.**
Each cycle's own realistic likelihood deserves its own honest discussion.

2 **Financial discussion covers the immediate cycle cost but not the realistic possibility of needing further cycles.**
Genuine financial transparency includes the realistic full picture, not only the immediate cost.

3 **The conversation is thorough at initial consultation but not revisited as treatment progresses.**
Understanding and circumstances can genuinely change over the course of treatment.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current consent practice for individualised, not generic, success rate discussion.

Week 2 Build individualised success rate and unsuccessful-cycle discussion into the consent process.

Week 3 Establish upfront financial discussion covering realistic multiple-cycle possibility.

Ongoing Spot-check patient understanding of both clinical and financial realities.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient what success rate they were told, and compare it to this patient's actual individual profile.
This reveals whether figures given were genuinely individualised or generic.

Ask whether the possibility of needing more than one cycle was discussed before treatment began.
This is where financial transparency most commonly falls short in practice.

E-LEARNING academy.gmj.ge/amb-std13-4-informed-consent — 30 min · complete before self-assessment

	Standard 13.5 NON-NEGOTIABLE · *Standard 13: Fertility & IVF* **A Witnessing Protocol Prevents Gamete and Embryo Mix-Up**	ASSESSMENT ASF-AMB-STD13-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

13.5
NON-NEGOTIABLE
L1

THE STANDARD

A Witnessing Protocol Prevents Gamete and Embryo Mix-Up

Every critical step involving gamete or embryo handling — collection, insemination, cryopreservation, thaw, transfer — is verified through a defined witnessing protocol, either double manual witnessing by a second qualified person or a certified electronic witnessing system, with every step traceable.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every critical step — collection, insemination, cryopreservation, thaw, transfer — covered by a defined witnessing protocol?** *Every critical step specifically, not a general awareness of the importance of care.* Doc: Witnessing protocol coverage documentation	YES	PARTIAL	NO
2	**Is witnessing genuinely independent — a second qualified person or certified electronic system — not the same person self-confirming?** *Genuine independence, whether human or verified electronic system.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is every witnessed step traceable after the fact, with a retained record of who witnessed what and when?** *A real, retained record, not an assumption that witnessing happened because the protocol exists.* Doc: Witnessing traceability record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Protocol coverage review*	Reviews the witnessing protocol for coverage of every critical handling step.
OBSERVE *Witnessing independence observation*	Observes an actual witnessed step for genuine independence between the operator and witness.
DOCUMENT *Traceability record review*	Reviews records for retained, specific traceability of witnessed steps.

REFERENCES

[69] Human Fertilisation and Embryology Authority. Code of Practice. 9th ed. London: HFEA; 2021 — mandates witnessing, either double manual witnessing by a second qualified individual or a certified electronic witnessing system, at every critical step of gamete and embryo handling.

Standard 13.5 · *Standard 13: Fertility & IVF*

Guidance & Learning

GUIDANCE ASF-AMB-STD13-v3.0

WHY THIS STANDARD EXISTS

A gamete or embryo mix-up is among the most serious possible errors in any medical setting, and while genuinely rare, it is real and documented — a defined, verified witnessing protocol at every critical step is what makes this risk structurally difficult, not just hoped against.

The evidence: [69] Human Fertilisation and Embryology Authority. Code of Practice. 9th ed. London: HFEA; 2021 — mandates witnessing, either double manual witnessing by a second qualified individual or a certified electronic witnessing system, at every critical step of gamete and embryo handling.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every critical step is covered by a defined witnessing protocol.	✗ Some critical steps lack a defined witnessing protocol.
✓ Witnessing is genuinely independent, whether manual or certified electronic.	✗ Witnessing is not genuinely independent, or is skipped under time pressure.
✓ Every witnessed step is traceable through a retained, specific record.	✗ No retained record exists confirming witnessing actually occurred for a given step.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Witnessing is rigorous for embryo transfer but less consistently applied to earlier steps like insemination.**
Every critical step carries the same real mix-up risk, not transfer alone.

2 **An electronic witnessing system exists but isn't used consistently for every applicable step.**
A system that exists but isn't consistently used doesn't provide the intended protection.

3 **Witnessing happens but records don't specify exactly which steps were witnessed by whom.**
Traceability requires specific, retained detail, not a general confirmation witnessing occurred.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Map every critical gamete and embryo handling step against current witnessing coverage.

Week 2 Close any gap in witnessing coverage for critical steps.

Week 3 Establish specific, retained traceability records for every witnessed step.

Ongoing Audit witnessing consistency and traceability records periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the traceability record for a specific, recent case.
A specific, real record is the only genuine evidence witnessing actually happened as described.

Observe a witnessed step directly if timing allows.
Genuine independence between operator and witness is best confirmed through direct observation.

E-LEARNING academy.gmj.ge/amb-std13-5-witnessing-protocol — 30 min · complete before self-assessment

STANDARD 14

Cardiology & Cardiac Catheterization

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

3 criteria

	Standard 14.1 NON-NEGOTIABLE · *Standard 14: Cardiology & Cardiac Catheterization* **Contrast Media Reaction Response Is Rehearsed, Not Theoretical**	ASSESSMENT ASF-AMB-STD14-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

14.1
NON-NEGOTIABLE
L1

THE STANDARD

Contrast Media Reaction Response Is Rehearsed, Not Theoretical

Staff are trained and drilled — not only briefed — on recognising and managing contrast media hypersensitivity reactions, with a risk-based premedication and management approach for patients with prior reaction history, and emergency treatment genuinely available at the point of contrast administration.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Have staff actually rehearsed a contrast reaction response, not only reviewed a written protocol?** *A genuine drill, not a policy document read once.* Doc: Drill record, date and participants	YES	PARTIAL	NO
2	**Does the facility's approach to prior-reaction patients reflect current, evidence-based guidance, not outdated assumptions?** *Current practice, specifically checked against recent guidance updates.* Doc: Premedication and management protocol document	YES	PARTIAL	NO
3	**Is emergency treatment for anaphylaxis genuinely available at the point of contrast administration, not in a separate location?** *Immediately at hand, not requiring retrieval during an emergency.* Doc: Emergency treatment stock and location record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Drill record review*	Reviews records of actual rehearsed contrast reaction response drills.
DOCUMENT *Protocol currency review*	Reviews the facility's premedication and management protocol against current guidance.
OBSERVE *Emergency treatment location check*	Confirms emergency treatment is genuinely available at the point of contrast administration.

REFERENCES

[70] Established professional consensus guidance on the management and prevention of hypersensitivity reactions to radiocontrast media establishes risk-based, evidence-updated management of contrast hypersensitivity, including current guidance on premedication versus agent substitution.

Standard 14.1 · *Standard 14: Cardiology & Cardiac Catheterization*

Guidance & Learning

GUIDANCE ASF-AMB-STD14-v3.0

WHY THIS STANDARD EXISTS

Contrast reactions can range from mild to genuinely life-threatening anaphylaxis, and guidance on managing prior-reaction patients has evolved meaningfully in recent years — a facility working from outdated assumptions about premedication may not reflect the actual current, evidence-based approach.

The evidence: [70] Established professional consensus guidance on the management and prevention of hypersensitivity reactions to radiocontrast media establishes risk-based, evidence-updated management of contrast hypersensitivity, including current guidance on premedication versus agent substitution.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff have genuinely rehearsed the response, with dated drill records.	✗ Only written protocol review has occurred, with no actual drill.
✓ The facility's protocol reflects current, evidence-based guidance.	✗ The protocol reflects outdated premedication assumptions.
✓ Emergency treatment is immediately available at the point of administration.	✗ Emergency treatment requires retrieval from another location.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A drill was conducted once but hasn't been repeated since.**
Rehearsed response capability fades over time without periodic repetition.

2 **The protocol was updated for severe reaction cases but not for mild prior-reaction management.**
Guidance has meaningfully changed for mild reaction management specifically, not only severe cases.

3 **Emergency treatment is nearby but not genuinely at every point where contrast is administered.**
A reaction can occur wherever contrast is given, and treatment needs to be immediately reachable from there.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current protocol against the most recent contrast hypersensitivity guidance.

Week 2 Conduct an actual reaction response drill with all relevant staff.

Week 3 Verify emergency treatment is genuinely accessible at every point of contrast administration.

Ongoing Repeat drills periodically and review protocol currency as guidance evolves.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the date of the last actual drill, not the date the protocol was written.
A specific, recent drill date is the real evidence of rehearsed readiness.

Ask specifically about management of a patient with a prior mild reaction.
This is exactly where guidance has changed most recently, and where outdated practice most commonly persists.

E-LEARNING academy.gmj.ge/amb-std14-1-contrast-reaction — 30 min · complete before self-assessment

	Standard 14.2 NON-NEGOTIABLE · *Standard 14: Cardiology & Cardiac Catheterization* **Vascular Access Site Complications Are Actively Monitored**	ASSESSMENT ASF-AMB-STD14-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

14.2
NON-NEGOTIABLE
L1

THE STANDARD

Vascular Access Site Complications Are Actively Monitored

Patients are monitored for vascular access site complications — bleeding, hematoma, pseudoaneurysm — on a defined schedule appropriate to the access site used, with staff specifically trained on the distinct complication patterns of the access site actually used for each patient.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is monitoring specific to the actual access site used for each patient, not a generic approach applied regardless?** *Site-specific monitoring, reflecting the genuinely different risk pattern of radial versus femoral access.* Doc: Access-site-specific monitoring protocol	YES	PARTIAL	NO
2	**Are staff specifically trained to recognise complications distinct to each access site type used at this facility?** *Specific training matched to the access types actually used, not general awareness.* Doc: Access-site complication training record	YES	PARTIAL	NO
3	**Is monitoring conducted on a defined schedule appropriate to the access site, with findings documented?** *A specific, followed schedule, not informal or inconsistent checking.* Doc: Monitoring schedule and documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Monitoring protocol review*	Reviews the monitoring protocol for genuine access-site specificity.
DOCUMENT *Training record review*	Reviews training records for access-site-specific complication recognition.
OBSERVE *Monitoring practice observation*	Observes actual post-procedure monitoring practice for schedule adherence.

REFERENCES

[71] Access-site-specific complication monitoring, reflecting genuinely different risk profiles and presentation patterns between radial and femoral vascular access, is established practice in interventional cardiology safety literature.

Standard 14.2 · *Standard 14: Cardiology & Cardiac Catheterization*

Guidance & Learning

GUIDANCE ASF-AMB-STD14-v3.0

WHY THIS STANDARD EXISTS

Access site complication risk and presentation genuinely differ between radial and femoral approaches, and monitoring built around one access type's typical pattern can miss a complication developing differently at the other.

The evidence: [71] Access-site-specific complication monitoring, reflecting genuinely different risk profiles and presentation patterns between radial and femoral vascular access, is established practice in interventional cardiology safety literature.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Monitoring is genuinely specific to the access site actually used.	✗ A generic monitoring approach is applied regardless of access site.
✓ Staff are specifically trained on complications distinct to each access type used here.	✗ Training doesn't distinguish between access-site-specific complication patterns.
✓ Monitoring follows a defined, documented schedule.	✗ Monitoring is informal or inconsistently documented.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Femoral access monitoring is thorough but radial-specific monitoring is less developed.**
Facilities transitioning toward radial access sometimes retain monitoring protocols built for femoral risk patterns.

2 **Training covers major complications but not more subtle, access-specific presentation patterns.**
Early, subtle signs are exactly where access-specific knowledge matters most for catching a problem early.

3 **Monitoring happens but documentation is inconsistent across shifts.**
Undocumented monitoring is difficult to distinguish from monitoring that didn't happen.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current monitoring practice for genuine access-site specificity.

Week 2 Update training to cover complication patterns specific to each access type used.

Week 3 Establish a defined, documented monitoring schedule for each access type.

Ongoing Audit monitoring documentation consistency across shifts.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to describe the specific complication signs for the access site used in a recent case.
Specificity reveals whether training genuinely reflects access-site differences.

Check monitoring documentation across different shifts, not just one.
Consistency across shifts reveals whether this is genuine, embedded practice.

E-LEARNING academy.gmj.ge/amb-std14-2-access-site-monitoring — 30 min · complete before self-assessment

	Standard 14.3 NON-NEGOTIABLE · *Standard 14: Cardiology & Cardiac Catheterization* **Radiation Exposure to Patients and Staff Is Tracked and Limited**	ASSESSMENT ASF-AMB-STD14-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

14.3
NON-NEGOTIABLE
L1

THE STANDARD

Radiation Exposure to Patients and Staff Is Tracked and Limited

Radiation dose to both patients and staff is tracked per procedure, using ALARA-consistent technique to minimise exposure, with cumulative staff exposure monitored against recognised occupational limits — not managed only by general awareness that radiation exposure matters.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is patient radiation dose tracked per procedure, with the data reviewed, not just generated and filed?** *Genuine tracking and review, not data collected without ever being examined.* Doc: Patient dose tracking record	YES	PARTIAL	NO
2	**Are ALARA-consistent technique practices — collimation, appropriate frame rate, distance optimisation — genuinely applied, not just known about?** *Applied in actual practice, not simply familiar concepts.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is cumulative staff radiation exposure monitored against recognised occupational limits, with dosimetry genuinely worn and reviewed?** *Real, worn dosimetry with genuine review, not badges issued but not consistently used or checked.* Doc: Staff dosimetry and exposure tracking record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Patient dose tracking review*	Reviews patient radiation dose records for consistency and genuine review.
OBSERVE *ALARA technique observation*	Observes actual procedural technique for ALARA-consistent practice.
DOCUMENT *Staff dosimetry review*	Reviews staff dosimetry records against recognised occupational exposure limits.

REFERENCES

[72] Established clinical expert consensus on cardiac catheterization laboratory standards establishes ALARA (as low as reasonably achievable) as the governing principle for radiation use in the catheterization laboratory, with defined occupational exposure limits for staff.

Standard 14.3 · *Standard 14: Cardiology & Cardiac Catheterization*

Guidance & Learning

GUIDANCE ASF-AMB-STD14-v3.0

WHY THIS STANDARD EXISTS

Interventional cardiology carries among the highest occupational radiation exposure of any medical specialty, and there is no radiation dose considered completely without risk — which is exactly why tracked, deliberate minimisation, not general caution alone, is the established standard.

The evidence: [72] Established clinical expert consensus on cardiac catheterization laboratory standards establishes ALARA (as low as reasonably achievable) as the governing principle for radiation use in the catheterization laboratory, with defined occupational exposure limits for staff.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Patient dose is tracked per procedure and genuinely reviewed.	✗ Dose data, if collected, is never reviewed.
✓ ALARA-consistent technique is genuinely applied in practice.	✗ ALARA principles are known but not consistently applied in actual technique.
✓ Staff dosimetry is consistently worn and reviewed against occupational limits.	✗ Dosimetry badges are issued but not consistently worn or reviewed.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Patient dose is tracked but not reviewed for trends across the practice.**
Individual case tracking without trend review misses systemic patterns worth addressing.

2 **ALARA technique is applied by senior staff but less consistently by newer team members.**
Consistent radiation safety practice needs to extend to everyone performing procedures, not only the most experienced.

3 **Dosimetry is worn but exposure data isn't reviewed on a regular schedule.**
Worn dosimetry without regular review limits the ability to catch a concerning exposure trend before it becomes serious.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current patient dose tracking and staff dosimetry practice.

Week 2 Establish or strengthen ALARA-consistent technique training for all staff.

Week 3 Establish a regular schedule for reviewing both patient dose trends and staff exposure data.

Ongoing Review dose and exposure data on the established schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see actual dose tracking data and staff dosimetry records, not a general assurance of radiation safety awareness.
Specific, dated records are the only real evidence of genuine tracking.

Observe actual procedural technique for specific ALARA practices — collimation, frame rate, distance.
Direct observation reveals whether ALARA is genuinely applied, not just a familiar concept.

E-LEARNING academy.gmj.ge/amb-std14-3-radiation-safety — 30 min · complete before self-assessment

STANDARD 15

Ophthalmology & Day Surgery

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

3 criteria

	Standard 15.1 NON-NEGOTIABLE · *Standard 15: Ophthalmology & Day Surgery* **Endophthalmitis Prevention Protocol Is Followed Precisely, Not Approximately**	ASSESSMENT ASF-AMB-STD15-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

15.1
NON-NEGOTIABLE
L1

THE STANDARD

Endophthalmitis Prevention Protocol Is Followed Precisely, Not Approximately

Cataract and other intraocular procedures follow a precise, evidence-based endophthalmitis prevention protocol — specific povidone-iodine antisepsis timing and intracameral antibiotic use — verified as actually followed to the letter, not approximated or applied loosely.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is povidone-iodine antisepsis applied with the specific, evidence-based timing — not just used generally at some point before surgery?** *A specific timing protocol, not general antiseptic use approximated by feel.* Doc: Antisepsis protocol document	YES	PARTIAL	NO
2	**Is intracameral antibiotic prophylaxis used at the specific dose supported by evidence, prepared correctly to avoid dilution error?** *The specific, evidence-supported approach, prepared with genuine care against a known error risk.* Doc: Intracameral antibiotic protocol and preparation record	YES	PARTIAL	NO
3	**Is the actual protocol followed verified periodically, not assumed from the fact that a protocol exists?** *Genuine verification, not an assumption that a written protocol is automatically followed precisely.* Doc: Protocol adherence verification record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Antisepsis protocol review*	Reviews the specific antisepsis timing protocol against evidence-based recommendations.
OBSERVE *Intracameral antibiotic preparation observation*	Observes actual preparation of intracameral antibiotic for correct dose and dilution.
DOCUMENT *Protocol adherence verification review*	Reviews evidence that the protocol is periodically verified as actually followed.

REFERENCES

[73] Barry P, Seal DV, Gettinby G, Lees F, Peterson M, Revie CW; ESCRS Endophthalmitis Study Group. ESCRS study of prophylaxis of postoperative endophthalmitis after cataract surgery: preliminary report of principal results from a European multicenter study. J Cataract Refract Surg. 2006;32(3):407-410 — a multicenter study of over 16,000 patients demonstrating a near five-fold reduction in endophthalmitis with intracameral antibiotic prophylaxis.

Standard 15.1 · *Standard 15: Ophthalmology & Day Surgery*

Guidance & Learning

GUIDANCE ASF-AMB-STD15-v3.0

WHY THIS STANDARD EXISTS

Endophthalmitis is a rare but genuinely devastating complication that can cause permanent vision loss, and the evidence specifically shows that precise protocol details — exact antisepsis timing, specific antibiotic and dose — meaningfully change the actual risk, not just the general idea of using antiseptic and antibiotic.

The evidence: [73] Barry P, Seal DV, Gettinby G, Lees F, Peterson M, Revie CW; ESCRS Endophthalmitis Study Group. ESCRS study of prophylaxis of postoperative endophthalmitis after cataract surgery: preliminary report of principal results from a European multicenter study. J Cataract Refract Surg. 2006;32(3):407-410 — a multicenter study of over 16,000 patients demonstrating a near five-fold reduction in endophthalmitis with intracameral antibiotic prophylaxis.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Antisepsis timing precisely follows the evidence-based protocol.	✗ Antiseptic is used but timing isn't specifically controlled or verified.
✓ Intracameral antibiotic is prepared correctly at the specific evidence-supported dose.	✗ Intracameral antibiotic preparation carries meaningful risk of dilution error.
✓ Protocol adherence is periodically verified, not just assumed.	✗ No verification happens beyond the protocol existing on paper.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Antisepsis is used consistently but exact timing varies by individual surgeon's practice.**
The specific timing itself is part of what the evidence supports, not general antiseptic use alone.

2 **Intracameral antibiotic is used but preparation isn't specifically double-checked for dilution accuracy.**
Dilution error is a specifically documented risk with this exact preparation.

3 **The protocol is written precisely but hasn't been recently verified against actual practice.**
A precise protocol on paper doesn't guarantee precise practice without periodic verification.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current antisepsis and intracameral antibiotic practice against the specific evidence-based protocol.

Week 2 Standardise antisepsis timing and antibiotic preparation across all surgeons.

Week 3 Establish a periodic verification process for actual protocol adherence.

Ongoing Re-verify adherence periodically, particularly with any change in surgical staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a specific surgeon to describe their exact antisepsis timing, not a general description.
Specificity reveals whether the precise, evidence-based protocol is genuinely followed.

Observe intracameral antibiotic preparation directly if timing allows.
Direct observation is the clearest evidence of correct, careful preparation against dilution error.

E-LEARNING academy.gmj.ge/amb-std15-1-endophthalmitis-prevention — 30 min · complete before self-assessment

	Standard 15.2 CORE · *Standard 15: Ophthalmology & Day Surgery* **Surgical Consent Covers Realistic Outcome Expectations, Not Just Risk**	ASSESSMENT ASF-AMB-STD15-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

15.2
CORE
L1

THE STANDARD

Surgical Consent Covers Realistic Outcome Expectations, Not Just Risk

Consent for cataract and refractive procedures includes a genuine, honest discussion of realistic outcome expectations — including the real possibility of needing glasses afterward, or less than perfect vision — not only a list of physical risks with success implicitly assumed.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does consent genuinely discuss realistic visual outcome expectations, not only physical risks?** *A real discussion of what vision will likely be like afterward, not just what could go wrong.* Doc: Outcome expectation discussion documentation	YES	PARTIAL	NO
2	**Is the real possibility of still needing glasses, or less than perfect vision, explicitly discussed?** *Honest, specific discussion, not an assumption of a perfect outcome.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Can the patient explain back realistic expectations for their own specific case?** *Tests genuine understanding specific to this patient, not general awareness that outcomes vary.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Outcome discussion review*	Reviews consent documentation for genuine outcome expectation discussion, not risk disclosure alone.
OBSERVE *Consent conversation observation*	Observes an actual consent conversation for genuine discussion of realistic outcomes.
ASK *Patient understanding check*	Asks a patient to describe realistic expectations for their own specific procedure.

REFERENCES

[74] Realistic, individualised discussion of expected visual outcomes, distinct from physical risk disclosure alone, is identified in ophthalmic surgery literature as a determinant of patient satisfaction independent of surgical success.

Standard 15.2 · *Standard 15: Ophthalmology & Day Surgery*

Guidance & Learning

GUIDANCE ASF-AMB-STD15-v3.0

WHY THIS STANDARD EXISTS

Patient dissatisfaction after eye surgery often stems not from a complication, but from an outcome that was technically successful yet didn't match unrealistic expectations the consent process never actually addressed.

The evidence: [74] Realistic, individualised discussion of expected visual outcomes, distinct from physical risk disclosure alone, is identified in ophthalmic surgery literature as a determinant of patient satisfaction independent of surgical success.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Consent genuinely discusses realistic visual outcome expectations.	✗ Consent lists physical risks only, with success implicitly assumed.
✓ The possibility of still needing glasses or imperfect vision is explicitly, honestly discussed.	✗ Glasses or imperfect outcome possibility isn't discussed.
✓ Patients can explain back realistic expectations specific to their own case.	✗ Patients cannot describe realistic expectations for their own case.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Outcome discussion happens for complex cases but is abbreviated for routine cataract surgery.**
Even routine-seeming procedures benefit from genuinely realistic expectation-setting.

2 **Glasses possibility is mentioned but not discussed in enough detail for genuine understanding.**
A passing mention isn't the same as a patient genuinely internalising a realistic expectation.

3 **Discussion happens well before surgery but isn't reconfirmed closer to the actual procedure date.**
Patient understanding can fade or shift in the time between initial discussion and the actual procedure.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current consent practice for genuine outcome expectation discussion.

Week 2 Build specific, honest outcome discussion into the standard consent process.

Week 3 Train staff to verify patient understanding of realistic expectations, not just obtain a signature.

Ongoing Spot-check patient understanding of expectations after consent conversations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the patient what they expect their vision to be like afterward.
This tests actual understanding and expectation-setting, not just that risks were listed.

Check consent practice for routine cataract cases specifically, not only complex ones.
Genuine expectation-setting matters even when the procedure feels routine.

E-LEARNING academy.gmj.ge/amb-std15-2-outcome-consent — 30 min · complete before self-assessment

	Standard 15.3 NON-NEGOTIABLE · *Standard 15: Ophthalmology & Day Surgery* **Post-Procedure Vision Is Checked Before Discharge, Not Assumed Stable**	ASSESSMENT ASF-AMB-STD15-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

15.3
NON-NEGOTIABLE
L1

THE STANDARD

Post-Procedure Vision Is Checked Before Discharge, Not Assumed Stable

Every patient undergoes a genuine post-procedure vision and eye check before discharge, with specific criteria for what triggers extended observation or same-day escalation — not discharged based on general appearance or the patient simply feeling ready to leave.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does every patient undergo a genuine, specific vision and eye check before discharge, not a general assessment of how they seem?** *A specific clinical check, not a general impression.* Doc: Pre-discharge assessment documentation	YES	PARTIAL	NO
2	**Are there specific, defined criteria for what would trigger extended observation or escalation?** *Specific, known criteria, not a vague sense that something seems off.* Doc: Extended observation criteria document	YES	PARTIAL	NO
3	**Is the check performed by someone specifically qualified to recognise early signs of complication?** *A qualified assessor, not whoever happens to be available at discharge time.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Pre-discharge assessment review*	Reviews documentation for genuine, specific vision and eye assessment before discharge.
DOCUMENT *Escalation criteria review*	Reviews the specific, defined criteria for extended observation or escalation.
OBSERVE *Assessor qualification check*	Confirms the pre-discharge check is performed by someone specifically qualified to recognise complications.

REFERENCES

[75] Structured post-procedure ocular assessment prior to discharge, with defined criteria for extended observation, is established practice in ambulatory ophthalmic surgery to catch early complications while the patient remains on-site.

Standard 15.3 · *Standard 15: Ophthalmology & Day Surgery*

Guidance & Learning

GUIDANCE ASF-AMB-STD15-v3.0

WHY THIS STANDARD EXISTS

A serious early complication can present subtly, and discharging a patient without a genuine, specific check means the first real opportunity to catch a developing problem — while the patient is still on-site and can be immediately managed — has already passed.

The evidence: [75] Structured post-procedure ocular assessment prior to discharge, with defined criteria for extended observation, is established practice in ambulatory ophthalmic surgery to catch early complications while the patient remains on-site.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every patient undergoes a genuine, specific pre-discharge assessment. ✓ Specific, defined criteria exist for extended observation or escalation. ✓ The assessment is performed by someone specifically qualified for it.	✗ Discharge is based on general appearance or patient readiness alone. ✗ No specific criteria exist beyond general judgement about whether something seems wrong. ✗ The check, if performed, is done by whoever is available, not specifically qualified staff.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Assessment is thorough for complex procedures but abbreviated for routine cataract cases.**
Early complications can occur even after routine-seeming procedures.

2 **Criteria for escalation exist but aren't consistently applied by all staff performing discharge checks.**
Written criteria only provide real protection when consistently applied by everyone using them.

3 **The assessment happens but timing is rushed during busy periods.**
A rushed check risks missing exactly the subtle signs this assessment exists to catch.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current discharge practice for genuine, specific vision and eye assessment.

Week 2 Establish specific, defined criteria for extended observation or escalation.

Week 3 Ensure the assessment is consistently performed by specifically qualified staff.

Ongoing Audit discharge assessment consistency, particularly during busy periods.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask what specifically would trigger extended observation, not a general description of the discharge process.
Specific, known criteria reveal genuine readiness versus a general policy statement.

Observe an actual discharge assessment if timing allows.
Direct observation reveals whether this is a genuine, specific check or a general impression.

E-LEARNING academy.gmj.ge/amb-std15-3-discharge-vision-check — 30 min · complete before self-assessment

STANDARD 16

Diagnostic Imaging

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

3 criteria