Standard 16.1 **NON-NEGOTIABLE** · *Standard 16: Diagnostic Imaging*

CT Radiation Dose Is Tracked and Benchmarked, Not Just Delivered

ASSESSMENT ASF-AMB-STD16-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

16.1
NON-NEGOTIABLE
L1

THE STANDARD

CT Radiation Dose Is Tracked and Benchmarked, Not Just Delivered

CT radiation dose is tracked per examination and periodically benchmarked against recognised national or international diagnostic reference levels, with protocols reviewed and adjusted when dose consistently runs high — not delivered and filed with no comparison to any external standard.

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

1	**Is radiation dose tracked for every CT examination, not only sampled occasionally?** *Consistent tracking for every examination, not periodic spot-checking alone.* Doc: Dose tracking record	YES	PARTIAL	NO
2	**Is facility dose data periodically compared against a recognised external benchmark, not only reviewed internally?** *A real external reference point, not only comparison against the facility's own historical data.* Doc: Benchmarking comparison record	YES	PARTIAL	NO
3	**When dose consistently runs high against the benchmark, is the protocol actually reviewed and adjusted?** *Genuine review leading to action, not benchmarking data collected without consequence.* Doc: Protocol review and adjustment 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 *Dose tracking review*	Reviews dose tracking records for consistency across CT examinations.
DOCUMENT *Benchmarking record review*	Reviews evidence of periodic comparison against a recognised external dose benchmark.
ASK *Protocol adjustment interview*	Asks staff for a real example where benchmarking led to a protocol review or adjustment.

REFERENCES

[76] Established radiology practice guidance for performing and interpreting diagnostic computed tomography requires facility dose data to be compared against recognised benchmarks, with protocol review when dose consistently exceeds expected levels.

Standard 16.1 · *Standard 16: Diagnostic Imaging*
Guidance & Learning

GUIDANCE ASF-AMB-STD16-v3.0

WHY THIS STANDARD EXISTS

A dose that seems reasonable in isolation can still be meaningfully higher than what similar facilities achieve for the same examination, and without benchmarking against a real external reference, a facility has no way to know whether its own protocols are actually well-optimised or just familiar.

The evidence: [76] Established radiology practice guidance for performing and interpreting diagnostic computed tomography requires facility dose data to be compared against recognised benchmarks, with protocol review when dose consistently exceeds expected levels.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Dose is tracked consistently for every CT examination.	✗ Dose tracking is occasional or incomplete.
✓ Facility data is periodically compared against a recognised external benchmark.	✗ No external benchmark comparison happens, only internal review if any.
✓ A real example exists of benchmarking leading to protocol review and adjustment.	✗ Benchmarking data, if collected, has never led to a protocol change.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Dose is tracked for common examination types but not less frequent ones.**
Every examination type carries the same real benchmarking value, not only high-volume ones.

2 **Benchmarking happens but the comparison reference used is outdated.**
Reference levels are periodically updated, and comparison against an outdated benchmark may not reflect current best practice.

3 **High-dose findings are noted but protocol review doesn't consistently follow.**
Noticing a high-dose pattern without acting on it doesn't provide the real protection benchmarking is meant to offer.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current dose tracking coverage across all CT examination types.

Week 2 Establish or verify periodic comparison against a recognised, current external benchmark.

Week 3 Establish a defined process for protocol review when dose consistently runs high.

Ongoing Repeat benchmarking comparison periodically and track resulting protocol changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for actual benchmarking comparison data, not a general assurance that dose is monitored.
Specific, dated comparison records are the only real evidence of genuine benchmarking.

Ask for a real example where a protocol was changed because of a benchmarking finding.
A real example reveals whether benchmarking leads to genuine action, not just data collection.

E-LEARNING academy.gmj.ge/amb-std16-1-ct-dose-benchmarking — 30 min · complete before self-assessment

Standard 16.2 **NON-NEGOTIABLE** · *Standard 16: Diagnostic Imaging*

MRI Safety Screening Happens Before Every Scan, Not Assumed From Intake

ASSESSMENT ASF-AMB-STD16-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

16.2
NON-NEGOTIABLE
L1

THE STANDARD

MRI Safety Screening Happens Before Every Scan, Not Assumed From Intake

Every patient undergoes a genuine, verbal MRI safety screening immediately before entering the scan room, reviewing a completed written questionnaire in full — not relying on an intake form completed earlier and never actively reviewed at the point of the actual scan.

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

1	**Does every patient undergo a genuine verbal screening review immediately before entering the scan room, not only earlier intake screening?** *A real, verbal review at the actual point of entry, not reliance on an earlier form alone.* Doc: Pre-scan verbal screening record	YES	PARTIAL	NO
2	**Is the full written questionnaire reviewed in its entirety, not just a quick verbal confirmation?** *Complete review of every question, not an abbreviated check.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are patients specifically asked to remove jewellery, metallic clothing items, and similar objects immediately before the scan?** *A specific, direct check, not an assumption the patient already did this.* 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 *Pre-scan screening observation*	Observes an actual pre-scan screening for genuine, complete verbal review immediately before entry.
DOCUMENT *Questionnaire completeness review*	Reviews completed questionnaires for full coverage, not abbreviated screening.
ASK *Technologist practice interview*	Asks a technologist to describe their specific pre-scan screening routine.

REFERENCES

[77] Established MRI safety guidance requires a written safety screening questionnaire reviewed orally with the patient in its entirety immediately prior to entry into the MRI scan area.

Standard 16.2 · *Standard 16: Diagnostic Imaging*
Guidance & Learning

GUIDANCE ASF-AMB-STD16-v3.0

WHY THIS STANDARD EXISTS

A ferromagnetic object entering the MRI's magnetic field can cause serious injury or death, and screening completed once at intake, days or hours before the actual scan, can miss a change — a new implant, a piece of information the patient didn't think to mention earlier, an item they're still wearing.

The evidence: [77] Established MRI safety guidance requires a written safety screening questionnaire reviewed orally with the patient in its entirety immediately prior to entry into the MRI scan area.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every patient undergoes genuine verbal screening immediately before entering the scan room.	✗ Screening relies on an intake form completed earlier, without review at the point of scanning.
✓ The full questionnaire is reviewed in its entirety at that point.	✗ Verbal review is abbreviated rather than covering the full questionnaire.
✓ Patients are specifically asked to remove relevant items immediately before the scan.	✗ Item removal is assumed rather than specifically checked.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Verbal screening happens but is rushed during busy scheduling periods.**
A rushed screening risks missing exactly the detail this process exists to catch.

2 **Screening is thorough for new patients but abbreviated for returning ones.**
A returning patient's circumstances — a new implant, a recent procedure — can genuinely have changed since their last scan.

3 **The questionnaire is reviewed but item removal isn't specifically, separately confirmed.**
Reviewing the questionnaire and physically confirming items are removed are two distinct, both necessary checks.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current pre-scan screening practice for genuine, complete verbal review.

Week 2 Reinforce full questionnaire review immediately before scan room entry for every patient.

Week 3 Establish a specific, separate item-removal confirmation step.

Ongoing Observe screening practice periodically, particularly during busy periods.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual pre-scan screening if timing allows.
Direct observation reveals whether this is a genuine, complete review or an abbreviated formality.

Ask about screening for a returning patient specifically.
This is where screening rigor most commonly, and riskily, relaxes in practice.

E-LEARNING academy.gmj.ge/amb-std16-2-mri-safety-screening — 30 min · complete before self-assessment

	Standard 16.3 **CORE** · *Standard 16: Diagnostic Imaging* **Contrast Media Protocols Match the Same Standard Used Elsewhere in This Facility**	**ASSESSMENT** ASF-AMB-STD16-v3.0
CR N/A	**TR** FULL	**SM** FULL	**ST** FULL

16.3
CORE
L1

THE STANDARD

Contrast Media Protocols Match the Same Standard Used Elsewhere in This Facility

Where imaging uses contrast media, the reaction recognition and management protocol is identical to the one used elsewhere in this facility for the same purpose — not a separate, independently developed protocol that may have quietly diverged from current guidance.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the contrast reaction protocol used in imaging identical to the one used elsewhere in this facility, not independently maintained?** *A genuinely shared, single protocol, not two versions that happen to be similar.* Doc: Cross-department protocol comparison	YES	PARTIAL	NO
2	**When the shared protocol is updated, does imaging's version update at the same time, not lag behind?** *Synchronised updates, not a separate update cycle for each department.* Doc: Protocol update record and timing	YES	PARTIAL	NO
3	**Are staff in imaging trained on the same protocol version as staff elsewhere in the facility?** *Consistent training content, not department-specific variations.* Doc: Training record comparison	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 *Cross-department protocol comparison*	Compares the imaging department's contrast protocol directly against the version used elsewhere in the facility.
DOCUMENT *Update synchronisation review*	Reviews update records to confirm imaging's protocol updates in sync with the shared version.
ASK *Staff training consistency interview*	Asks imaging staff to describe the protocol and compares against what other departments describe.

REFERENCES

[78] Consistency of contrast media reaction protocols across all departments within a single facility, rather than independently maintained departmental versions, is established practice for preventing protocol drift as clinical guidance evolves.

Standard 16.3 · *Standard 16: Diagnostic Imaging*
Guidance & Learning

GUIDANCE ASF-AMB-STD16-v3.0

WHY THIS STANDARD EXISTS

When different departments in the same facility each maintain their own contrast reaction protocol, they can quietly drift apart over time as guidance updates reach one but not the other — a genuine risk this facility has already specifically addressed for cardiology, and shouldn't allow to reappear here as a separate, unsynchronised version.

The evidence: [78] Consistency of contrast media reaction protocols across all departments within a single facility, rather than independently maintained departmental versions, is established practice for preventing protocol drift as clinical guidance evolves.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The imaging protocol is genuinely identical to the version used elsewhere in the facility.	✗ Imaging maintains its own separate protocol, independently developed.
✓ Protocol updates happen synchronously across departments.	✗ Imaging's protocol has visibly lagged behind updates made elsewhere.
✓ Staff training content is consistent across departments.	✗ Staff in different departments describe meaningfully different protocols.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 Protocols were identical when first established but have since quietly diverged.
Without an active synchronisation process, separately maintained copies of the same protocol drift apart over time.

2 The core protocol matches but emergency medication stock differs between departments.
A protocol match without matching resources doesn't provide the same real readiness.

3 Staff in imaging know the protocol exists but haven't been trained on the most recent update.
Training needs to be genuinely synchronised, not just protocol documentation.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Directly compare imaging's contrast protocol against the version used elsewhere in the facility.

Week 2 Resolve any divergence found, establishing one genuinely shared protocol.

Week 3 Establish a synchronised update process across departments.

Ongoing Periodically reconfirm protocol consistency across departments.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual protocol documents from both departments and compare them directly.
Direct comparison is the only real evidence of genuine consistency, not assumed alignment.

Ask staff in each department the same specific question and compare answers.
Consistent answers reveal genuine shared training; differing answers reveal quiet divergence.

E-LEARNING academy.gmj.ge/amb-std16-3-contrast-protocol-consistency — 30 min · complete before self-assessment

STANDARD 17

Dermatology

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

4 criteria

	Standard 17.1 NON-NEGOTIABLE · *Standard 17: Dermatology* **Biopsy Specimens Are Tracked to a Confirmed Pathology Result**	ASSESSMENT ASF-AMB-STD17-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

17.1
NON-NEGOTIABLE
L1

THE STANDARD

Biopsy Specimens Are Tracked to a Confirmed Pathology Result

Every skin biopsy is tracked from collection through to a confirmed, communicated pathology result, with a specific, named process ensuring no specimen result goes unreviewed or unreported to the patient — distinct from, and more specifically tracked than, general test results.

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

1	**Is there a specific, named tracking process for biopsy specimens, distinct from general test result tracking?** *A dedicated process specifically for biopsies, given the distinct severity risk.* Doc: Biopsy tracking log	YES	PARTIAL	NO
2	**Is there a way to identify a biopsy specimen whose result was never actually received or reviewed?** *An active mechanism that surfaces a gap, not one that only shows completed results.* Doc: Uncollected result identification process	YES	PARTIAL	NO
3	**Is the confirmed result specifically communicated to the patient, with the communication itself tracked?** *Tracked communication, not an assumption the patient was informed because the result exists in the chart.* Doc: Patient communication 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 *Biopsy tracking log review*	Reviews the specific biopsy tracking log for completeness from collection to confirmed result.
OBSERVE *Uncollected result identification check*	Checks whether the tracking system can actually surface a specimen whose result was never received.
DOCUMENT *Patient communication tracking review*	Reviews evidence that result communication to the patient is itself tracked, not assumed.

REFERENCES

[79] Failure to track biopsy specimens to a confirmed, communicated result is identified as a specific and serious contributor to delayed melanoma diagnosis in dermatology patient safety literature, distinct in severity from general diagnostic test follow-up.

Standard 17.1 · *Standard 17: Dermatology*

Guidance & Learning

GUIDANCE ASF-AMB-STD17-v3.0

WHY THIS STANDARD EXISTS

A missed or delayed biopsy result carries a specific, serious risk in dermatology that general test-result tracking may not fully capture — a missed melanoma diagnosis is a genuine, well-documented, sometimes fatal failure mode, and biopsy tracking deserves its own dedicated, higher-vigilance process, not just inclusion in a general results system.

The evidence: [79] Failure to track biopsy specimens to a confirmed, communicated result is identified as a specific and serious contributor to delayed melanoma diagnosis in dermatology patient safety literature, distinct in severity from general diagnostic test follow-up.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, dedicated biopsy tracking process exists, distinct from general results.	✗ Biopsies are tracked only within a general test-result system, with no distinct process.
✓ The system can identify and surface a specimen whose result was never received.	✗ There is no way to identify a specimen that fell through the cracks.
✓ Patient communication of the result is itself tracked, not assumed.	✗ Communication to the patient is assumed but not actually tracked.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Tracking exists for biopsies taken by the primary dermatologist but not consistently for those taken by covering staff.**
Every biopsy carries the same real risk, regardless of who performed it.

2 **The tracking log exists but isn't reviewed on a regular schedule to catch gaps.**
A log that isn't actively reviewed provides limited real protection against a missed result.

3 **Results are tracked internally but patient communication specifically isn't logged.**
An internally reviewed result that never reaches the patient still represents the failure this criterion exists to prevent.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current biopsy tracking practice for a specific, dedicated process.

Week 2 Establish a tracking log covering every biopsy from collection to confirmed, communicated result.

Week 3 Build a mechanism to actively surface any specimen without a received result.

Ongoing Review the tracking log on a regular schedule for gaps.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual tracking log and pick a specific, older biopsy to trace through it.
Tracing a real, specific case reveals whether the system genuinely works, not just whether it exists.

Ask specifically about biopsies taken by staff other than the primary dermatologist.
This is where tracking most commonly shows real gaps.

E-LEARNING academy.gmj.ge/amb-std17-1-biopsy-tracking — 30 min · complete before self-assessment

	Standard 17.2 NON-NEGOTIABLE · *Standard 17: Dermatology* **Cryotherapy and In-Office Procedures Follow a Defined Safety Protocol**	ASSESSMENT ASF-AMB-STD17-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

17.2
NON-NEGOTIABLE
L1

THE STANDARD

Cryotherapy and In-Office Procedures Follow a Defined Safety Protocol

Cryotherapy and other in-office dermatological procedures follow a defined protocol for technique, treatment depth appropriate to the lesion, and post-procedure care instruction — not applied based on individual practitioner habit without a documented, consistent standard.

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

1	**Does the practice follow a defined protocol for technique and treatment depth matched to lesion type?** *A specific, documented protocol, not individual practitioner habit alone.* Doc: Procedure protocol document	YES	PARTIAL	NO
2	**Is there a documented process for confirming a lesion's suitability for cryotherapy before treating, rather than a suspicious lesion being frozen without biopsy consideration?** *A specific decision point, not automatic treatment without considering whether biopsy is warranted first.* Doc: Lesion suitability assessment record	YES	PARTIAL	NO
3	**Is post-procedure care instruction given consistently, specific to the procedure performed?** *Consistent, procedure-specific instruction, not generic aftercare advice.* Doc: Post-procedure instruction 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 *Protocol review*	Reviews the defined technique and depth protocol against actual practice.
OBSERVE *Lesion suitability assessment observation*	Observes whether lesion suitability for cryotherapy versus biopsy is genuinely assessed before treatment.
DOCUMENT *Post-procedure instruction review*	Reviews post-procedure care documentation for consistency and procedure specificity.

REFERENCES

[80] Defined, lesion-appropriate technique and depth protocols for cryotherapy and similar in-office dermatological procedures are established practice for balancing treatment efficacy against the risk of under- or over-treatment.

Standard 17.2 · *Standard 17: Dermatology*
Guidance & Learning

GUIDANCE ASF-AMB-STD17-v3.0

WHY THIS STANDARD EXISTS

Cryotherapy and similar in-office procedures carry real risk of under-treatment, missing a lesion that needed more aggressive management, or over-treatment causing unnecessary scarring or damage — a defined protocol matched to lesion type is what keeps this risk genuinely managed rather than left to individual judgement alone.

The evidence: [80] Defined, lesion-appropriate technique and depth protocols for cryotherapy and similar in-office dermatological procedures are established practice for balancing treatment efficacy against the risk of under- or over-treatment.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A defined, documented protocol governs technique and treatment depth.	✗ Technique and depth vary by individual practitioner without a documented standard.
✓ Lesion suitability for cryotherapy versus biopsy is genuinely assessed before treatment.	✗ Suspicious lesions are treated without a genuine biopsy-versus-treatment decision.
✓ Post-procedure instruction is consistent and procedure-specific.	✗ Post-procedure instruction is generic or inconsistently given.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The protocol is followed by the primary dermatologist but not consistently by covering or newer staff.**
Consistency needs to extend to everyone performing the procedure, not only the most experienced practitioner.

2 **Lesion suitability assessment happens for obviously ambiguous cases but not routinely for all lesions.**
The decision to treat rather than biopsy deserves genuine consideration for every lesion, not only the visually ambiguous ones.

3 **Post-procedure instruction is given verbally but not consistently provided in writing.**
Written instruction the patient can refer back to is more reliable than a verbal explanation alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current technique and depth practice for consistency against a defined protocol.

Week 2 Establish or reinforce a genuine lesion-suitability assessment step before treatment.

Week 3 Standardise written post-procedure instruction specific to each procedure type.

Ongoing Audit protocol consistency across all practitioners performing procedures.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a practitioner to describe their decision process for a specific, recent case.
Specificity reveals whether a genuine, consistent protocol is followed, not individual habit.

Ask what would prompt biopsy instead of direct treatment for an ambiguous lesion.
A confident, specific answer reveals genuine, consistent clinical judgement embedded in practice.

E-LEARNING academy.gmj.ge/amb-std17-2-procedure-safety — 30 min · complete before self-assessment

	Standard 17.3 NON-NEGOTIABLE · *Standard 17: Dermatology* **Phototherapy Dosing Follows Evidence-Based Protocol, Not Estimation**	ASSESSMENT ASF-AMB-STD17-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

17.3
NON-NEGOTIABLE
L1

THE STANDARD

Phototherapy Dosing Follows Evidence-Based Protocol, Not Estimation

UV phototherapy dosing is based on minimal erythema dose testing or a defined skin-phototype protocol, with dose adjustment following specific, evidence-based rules based on erythema response — not estimated by practitioner judgement without a documented dosing framework.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is initial phototherapy dose based on minimal erythema dose testing or a defined skin-phototype protocol?** *A specific, evidence-based starting point, not an estimated or arbitrary initial dose.* Doc: Initial dosing protocol document	YES	PARTIAL	NO
2	**Does dose adjustment follow specific, defined rules based on the patient's actual erythema response?** *A specific rule set, not practitioner judgement applied inconsistently.* Doc: Dose adjustment protocol	YES	PARTIAL	NO
3	**Is cumulative UV exposure tracked over the course of treatment, not just each session's dose in isolation?** *Tracked cumulative exposure, since total lifetime UV exposure carries its own real, distinct risk.* Doc: Cumulative 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 *Initial dosing protocol review*	Reviews initial dosing practice against minimal erythema dose or skin-phototype protocol standards.
DOCUMENT *Dose adjustment record review*	Reviews dose adjustment records against specific, evidence-based erythema response rules.
DOCUMENT *Cumulative exposure tracking review*	Reviews whether cumulative UV exposure is tracked over the full course of treatment.

REFERENCES

[81] Established dermatology guidelines of care for the management and treatment of psoriasis with phototherapy establish minimal erythema dose or skin-phototype-based initial dosing, with specific dose adjustment rules based on erythema duration following treatment.

Standard 17.3 · *Standard 17: Dermatology*

Guidance & Learning

GUIDANCE ASF-AMB-STD17-v3.0

WHY THIS STANDARD EXISTS

Phototherapy dosing that isn't grounded in a defined protocol risks either under-dosing, reducing treatment effectiveness, or over-dosing, causing burns or unnecessarily high cumulative UV exposure — the evidence specifically defines how dose should adjust based on the patient's own erythema response, not general estimation.

The evidence: [81] Established dermatology guidelines of care for the management and treatment of psoriasis with phototherapy establish minimal erythema dose or skin-phototype-based initial dosing, with specific dose adjustment rules based on erythema duration following treatment.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Initial dose is based on minimal erythema dose testing or a defined skin-phototype protocol.	✗ Initial dose is estimated without a defined protocol.
✓ Dose adjustment follows specific, evidence-based rules tied to erythema response.	✗ Dose adjustment is based on general practitioner judgement without specific rules.
✓ Cumulative UV exposure is tracked over the full course of treatment.	✗ Cumulative exposure isn't tracked beyond individual session records.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Initial dosing follows the protocol but adjustment decisions become less rule-based as treatment continues.**
Adjustment discipline matters throughout the full course, not only at initiation.

2 **Dosing records exist per session but aren't summed to show cumulative exposure.**
Individual session records don't reveal the cumulative exposure picture that carries its own distinct risk.

3 **The protocol is followed for standard cases but less consistently for patients on photosensitising medications.**
Certain medications meaningfully change UV risk, and dosing decisions should reflect this.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current dosing practice against minimal erythema dose or skin-phototype protocol standards.

Week 2 Establish specific, documented dose adjustment rules based on erythema response.

Week 3 Build cumulative UV exposure tracking into the treatment record.

Ongoing Audit dosing decisions against the defined protocol periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the specific dose adjustment rule used for a documented erythema response.
A specific, correct answer reveals genuine protocol-based practice, not general estimation.

Ask to see cumulative exposure tracking for a patient partway through a treatment course.
This reveals whether cumulative risk is genuinely tracked, not just individual sessions.

E-LEARNING academy.gmj.ge/amb-std17-3-phototherapy-dosing — 30 min · complete before self-assessment

	Standard 17.4 NON-NEGOTIABLE · *Standard 17: Dermatology* **Suspicious Lesions Have a Defined, Timed Escalation Path**	ASSESSMENT ASF-AMB-STD17-v3.0
CR N/A	TR FULL	SM FULL	ST FULL

17.4
NON-NEGOTIABLE
L1

THE STANDARD

Suspicious Lesions Have a Defined, Timed Escalation Path

A lesion with suspicious features has a defined, timed escalation path — biopsy timeframe, referral pathway for advanced management — verified as actually followed, not left to case-by-case urgency judgement without a specific standard.

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

1	**Is there a specific, defined timeframe for biopsying a lesion identified as suspicious, not routine scheduling?** *A specific, known timeframe, not folded into normal appointment availability.* Doc: Escalation timeframe protocol	YES	PARTIAL	NO
2	**Is there a defined referral pathway to advanced management when findings warrant it?** *A specific, named pathway, not a general intention to refer if needed.* Doc: Referral pathway document	YES	PARTIAL	NO
3	**Is adherence to the escalation timeframe actually tracked, not assumed from the pathway existing on paper?** *Genuine tracking of actual timeframes achieved, not an assumption the pathway is followed.* Doc: Escalation timeframe adherence 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 *Escalation timeframe review*	Reviews the specific, defined timeframe for suspicious lesion biopsy.
DOCUMENT *Referral pathway review*	Reviews the specific, named referral pathway for advanced management.
DOCUMENT *Adherence tracking review*	Reviews records tracking whether the defined escalation timeframe is actually being met.

REFERENCES

[82] Defined, timed escalation pathways for suspicious skin lesions, distinct from routine follow-up scheduling, are established practice for minimising diagnostic delay in melanoma and other malignant skin lesions.

Standard 17.4 · *Standard 17: Dermatology*
Guidance & Learning

GUIDANCE ASF-AMB-STD17-v3.0

WHY THIS STANDARD EXISTS

The time between identifying a suspicious lesion and taking definitive action is a genuine, modifiable factor in outcome, particularly for melanoma — a defined, timed pathway removes the risk of a suspicious finding quietly losing urgency as it moves through scheduling and follow-up.

The evidence: [82] Defined, timed escalation pathways for suspicious skin lesions, distinct from routine follow-up scheduling, are established practice for minimising diagnostic delay in melanoma and other malignant skin lesions.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, defined timeframe governs suspicious lesion biopsy.	✗ Suspicious lesions are scheduled through routine, non-expedited booking.
✓ A specific, named referral pathway exists for advanced management.	✗ No specific referral pathway exists beyond general intention.
✓ Adherence to the timeframe is actively tracked, not assumed.	✗ No tracking exists to confirm the defined timeframe is actually being met.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A timeframe is defined but not consistently communicated to scheduling staff.**
A defined standard that scheduling staff don't know about doesn't reliably translate into faster action.

2 **The referral pathway exists but hasn't been used recently, so its current functioning is unverified.**
An untested pathway may not translate smoothly into real use when actually needed.

3 **Tracking exists but isn't reviewed for patterns of delay.**
Untracked or unreviewed data doesn't reveal whether the timeframe is genuinely being achieved.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current suspicious lesion scheduling against any existing timeframe standard.

Week 2 Define or reinforce a specific escalation timeframe and communicate it to scheduling staff.

Week 3 Confirm the referral pathway for advanced management is current and functioning.

Ongoing Track and review actual timeframe adherence for patterns.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask scheduling staff specifically what happens when a lesion is flagged as suspicious.
This reveals whether the defined timeframe genuinely reaches the people responsible for scheduling.

Ask for a real, recent example of the referral pathway being used.
A real example reveals whether the pathway genuinely functions, not just exists on paper.

E-LEARNING academy.gmj.ge/amb-std17-4-lesion-escalation — 30 min · complete before self-assessment

STANDARD 18

Allergy & Immunotherapy

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

3 criteria

	Standard 18.1 NON-NEGOTIABLE · *Standard 18: Allergy & Immunotherapy* **Post-Injection Observation Time Is Enforced, Not Assumed**	ASSESSMENT ASF-AMB-STD18-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

18.1
NON-NEGOTIABLE
L1

THE STANDARD

Post-Injection Observation Time Is Enforced, Not Assumed

Every patient receiving an allergen immunotherapy injection is observed on-site for the minimum required period afterward, with this actually enforced — not left to the patient's own judgement about whether they feel well enough to leave early.

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

1	**Is the minimum observation period actually enforced for every patient, not left to the patient's own judgement?** *Genuinely enforced, not a recommendation the patient can opt out of by feeling ready to leave.* Doc: Observation enforcement protocol	YES	PARTIAL	NO
2	**Is the patient's departure time actually recorded and compared against injection time?** *A real, checkable record, not an assumption the full period was observed.* Doc: Departure time tracking record	YES	PARTIAL	NO
3	**Is there a specific process for extending observation if symptoms develop during the standard window?** *A defined, known extension process, not uncertainty about what happens if something develops.* Doc: Extended observation 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 *Observation enforcement check*	Observes actual practice to confirm patients are genuinely held for the minimum period, not permitted to leave early.
DOCUMENT *Departure time record review*	Reviews records comparing injection time against actual departure time for a sample of patients.
ASK *Extended observation interview*	Asks staff what happens specifically if symptoms develop during the standard observation window.

REFERENCES

[83] Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, et al. Allergen immunotherapy: a practice parameter third update. J Allergy Clin Immunol. 2011;127(1 Suppl):S1-55 — establishes a minimum post-injection observation period as a core safety requirement of allergen immunotherapy administration.

Standard 18.1 · *Standard 18: Allergy & Immunotherapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD18-v3.0

WHY THIS STANDARD EXISTS

Systemic allergic reactions to immunotherapy injections typically develop within the standard observation window, and the protection this window provides only works if the patient is actually still on-site and being watched when a reaction begins — not already on their way home because they felt fine leaving.

The evidence: [83] Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, et al. Allergen immunotherapy: a practice parameter third update. J Allergy Clin Immunol. 2011;127(1 Suppl):S1-55 — establishes a minimum post-injection observation period as a core safety requirement of allergen immunotherapy administration.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The minimum observation period is genuinely enforced for every patient.	✗ Patients are permitted to leave early based on how they feel.
✓ Departure time is recorded and verifiably matches or exceeds the required period.	✗ No record exists comparing injection time against actual departure time.
✓ A specific, known process exists for extending observation when symptoms develop.	✗ Staff are uncertain what happens if symptoms develop during observation.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Observation is enforced during busy periods when staff are actively monitoring the waiting area, but less consistently when the area is quiet.**
The requirement doesn't depend on how busy the facility happens to be at the time.

2 **Departure time is recorded but not actually compared against injection time to verify compliance.**
A recorded time that's never checked against the requirement doesn't provide real verification.

3 **Extension happens for obvious reactions but the threshold for what warrants extension isn't clearly defined.**
A clear, specific threshold helps ensure consistent judgement across different staff members.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current observation practice for genuine enforcement, not patient-judgement-based departure.

Week 2 Establish a recorded departure time process, compared against injection time.

Week 3 Define and brief staff on a specific extended observation protocol.

Ongoing Audit departure time records against the minimum requirement periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see actual departure time records compared against injection times for real patients.
Specific, dated records are the only real evidence the requirement is genuinely enforced.

Observe the waiting area during a quiet period specifically.
Enforcement is most likely to relax exactly when the area feels calm and unhurried.

E-LEARNING academy.gmj.ge/amb-std18-1-observation-time — 30 min · complete before self-assessment

	Standard 18.2 NON-NEGOTIABLE · *Standard 18: Allergy & Immunotherapy* **Dose Escalation Follows a Defined, Individualized Schedule**	ASSESSMENT ASF-AMB-STD18-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

18.2
NON-NEGOTIABLE
L1

THE STANDARD

Dose Escalation Follows a Defined, Individualized Schedule

Immunotherapy dose escalation follows a defined schedule, individually adjusted for missed doses, prior reactions, and known risk factors — not advanced automatically according to a fixed calendar regardless of what actually happened at the previous visit.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is dose escalation adjusted for missed doses, not advanced automatically as if the prior visit occurred on schedule?** *A specific, defined adjustment rule for missed doses, not automatic progression.* Doc: Missed-dose adjustment protocol	YES	PARTIAL	NO
2	**Is dose escalation adjusted based on any reaction at the prior dose, not proceeding regardless?** *Genuine responsiveness to prior reaction history for this specific patient.* Doc: Prior-reaction dose adjustment record	YES	PARTIAL	NO
3	**Is the current dose and escalation status verified before each injection, not assumed from the calendar?** *An active check against the patient's actual record, not assumed from how much time has passed.* Doc: Pre-injection dose 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 *Missed-dose adjustment review*	Reviews records for evidence that missed doses trigger a defined adjustment, not automatic progression.
DOCUMENT *Prior-reaction adjustment review*	Reviews whether a prior reaction genuinely changes the subsequent dose decision.
OBSERVE *Pre-injection verification observation*	Observes whether dose and escalation status are actively verified against the patient's record before each injection.

REFERENCES

[84] Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, et al. Allergen immunotherapy: a practice parameter third update. J Allergy Clin Immunol. 2011;127(1 Suppl):S1-55 — establishes dose adjustment for missed doses and prior reactions as a core safety requirement of immunotherapy dose escalation.

Standard 18.2 · *Standard 18: Allergy & Immunotherapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD18-v3.0

WHY THIS STANDARD EXISTS

Advancing an immunotherapy dose without accounting for a missed prior dose or an earlier reaction meaningfully increases systemic reaction risk — the schedule needs to reflect what actually happened for this specific patient, not proceed as if every visit occurred exactly on time with no complications.

The evidence: [84] Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, et al. Allergen immunotherapy: a practice parameter third update. J Allergy Clin Immunol. 2011;127(1 Suppl):S1-55 — establishes dose adjustment for missed doses and prior reactions as a core safety requirement of immunotherapy dose escalation.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Missed doses trigger a specific, defined adjustment to the escalation schedule.	✗ Doses advance automatically according to a calendar regardless of missed visits.
✓ A prior reaction genuinely changes subsequent dose decisions.	✗ Prior reactions don't change subsequent dosing decisions.
✓ Dose and escalation status are actively verified against the record before each injection.	✗ Dose is assumed from time elapsed rather than verified against the actual record.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Missed-dose adjustment happens for longer gaps but not shorter, still-relevant delays.**
Even a shorter-than-expected gap can carry meaningful risk depending on the specific interval.

2 **Prior reactions are noted in the record but don't consistently change the next dose decision.**
A noted reaction that doesn't influence the subsequent decision doesn't provide the protection this criterion is meant to ensure.

3 **Verification happens for new or unusual cases but becomes less rigorous for routine, long-established patients.**
Established patients still benefit from the same active verification before each injection.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current escalation practice for genuine adjustment based on missed doses and prior reactions.

Week 2 Establish or reinforce a specific, defined missed-dose adjustment rule.

Week 3 Build active pre-injection verification into the standard workflow for every patient.

Ongoing Audit escalation decisions against missed-dose and prior-reaction adjustment rules.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real example of a missed dose and how the schedule was adjusted.
A real example reveals whether adjustment is genuine practice, not just a stated policy.

Ask staff to verify a specific patient's current dose status directly from the record, not from memory.
This reveals whether verification is genuinely active, not assumed from familiarity with a long-standing patient.

E-LEARNING academy.gmj.ge/amb-std18-2-dose-escalation — 30 min · complete before self-assessment

	Standard 18.3 **NON-NEGOTIABLE** · *Standard 18: Allergy & Immunotherapy* **Extract Preparation and Labeling Prevents Vial Mix-Up**	**ASSESSMENT** ASF-AMB-STD18-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

18.3
NON-NEGOTIABLE
L1

THE STANDARD

Extract Preparation and Labeling Prevents Vial Mix-Up

Allergen extract preparation, dilution, and labeling follows a defined, verified process specifically designed to prevent vial mix-up between patients — with a genuine, independent check before administration confirming the correct vial for the correct patient.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a defined process for preparing and labeling extract vials that specifically prevents mix-up between patients?** *A specific, designed process, not general care assumed to be sufficient.* Doc: Extract preparation and labeling protocol	YES	PARTIAL	NO
2	**Is there a genuine, independent check confirming the correct vial for the correct patient before administration, distinct from general patient identification?** *A specific vial-to-patient check, not folded into or assumed covered by general identification.* Doc: Vial verification record	YES	PARTIAL	NO
3	**Are vials specifically labeled with concentration and patient identity in a way that's checked, not just present?** *Genuinely checked labeling, not assumed correct because a label 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	
DOCUMENT *Preparation and labeling protocol review*	Reviews the defined process for extract preparation and labeling specific to mix-up prevention.
OBSERVE *Vial verification observation*	Observes an actual pre-administration check for genuine, independent vial-to-patient verification.
ASK *Labeling practice interview*	Asks staff to describe how they confirm vial concentration and patient identity match before administering.

REFERENCES

[85] Correct extract and concentration verification, distinct from and in addition to general patient identification, is established practice for preventing vial mix-up in allergen immunotherapy administration.

Standard 18.3 · *Standard 18: Allergy & Immunotherapy*

Guidance & Learning

GUIDANCE ASF-AMB-STD18-v3.0

WHY THIS STANDARD EXISTS

A vial mix-up between patients receiving different allergen extracts and concentrations is a serious, documented error type specific to immunotherapy practice, and the consequences of administering the wrong extract or the wrong concentration can be genuinely severe.

The evidence: [85] Correct extract and concentration verification, distinct from and in addition to general patient identification, is established practice for preventing vial mix-up in allergen immunotherapy administration.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, defined process prevents vial mix-up in preparation and labeling.	✗ No specific mix-up prevention process exists beyond general care.
✓ A genuine, independent vial-to-patient check happens before every administration.	✗ Vial verification isn't genuinely independent or is folded loosely into general patient identification.
✓ Labeling is specifically checked, not just present.	✗ Labels exist but aren't specifically checked before administration.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Verification is rigorous when a single patient is being seen but becomes less consistent during busy periods with multiple patients.**
Mix-up risk is highest exactly when multiple vials for different patients are present simultaneously.

2 **Labeling includes patient name but concentration isn't consistently double-checked.**
Correct patient with incorrect concentration still represents a real, distinct risk.

3 **The check happens but isn't genuinely independent — the same person prepares and verifies.**
Independent verification requires a second person's genuinely separate confirmation.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current extract preparation and labeling practice for mix-up prevention specificity.

Week 2 Establish a genuine, independent vial-to-patient verification step before every administration.

Week 3 Reinforce labeling practice to include both patient identity and concentration, both checked.

Ongoing Observe verification practice periodically, particularly during busy periods with multiple patients.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe during a period when multiple patients are being seen for injections.
This is exactly when mix-up risk is highest and verification discipline most likely to be tested.

Ask whether the same person both prepares and verifies, or whether this is genuinely independent.
Genuine independence between preparation and verification is what distinguishes a real check from a formality.

E-LEARNING academy.gmj.ge/amb-std18-3-extract-labeling — 30 min · complete before self-assessment

STANDARD 19

Plastic & Cosmetic Surgery

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

3 criteria

	Standard 19.1 **NON-NEGOTIABLE** · *Standard 19: Plastic & Cosmetic Surgery* **VTE Risk Is Assessed Using a Validated Score, Completed by the Physician**	**ASSESSMENT** ASF-AMB-STD19-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

19.1
NON-NEGOTIABLE
L1

THE STANDARD

VTE Risk Is Assessed Using a Validated Score, Completed by the Physician

Every patient undergoing a procedure under general anesthesia lasting over 60 minutes has a validated venous thromboembolism risk score completed by the physician, not the patient, with prophylaxis decided according to the resulting risk category — not assumed low-risk because the patient appears otherwise healthy.

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

1	**Is a validated VTE risk score completed by the physician, not the patient, for every applicable procedure?** *Physician-completed specifically, not relying on patient self-report.* Doc: VTE risk assessment record	YES	PARTIAL	NO
2	**Does the resulting risk category actually determine the prophylaxis decision, not just get recorded and set aside?** *Genuine, documented decision-making tied to the score, not a score calculated but not acted on.* Doc: Prophylaxis decision record linked to risk score	YES	PARTIAL	NO
3	**Is the risk score specifically re-assessed if the planned procedure changes in scope or duration?** *Reassessment reflecting the actual procedure performed, not the originally planned one.* 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 *Risk score completion review*	Reviews records confirming the VTE risk score was completed by the physician, not the patient.
DOCUMENT *Prophylaxis decision review*	Reviews whether the prophylaxis decision is genuinely tied to the documented risk score.
ASK *Reassessment practice interview*	Asks the physician whether and how the score is reassessed if procedure scope changes.

REFERENCES

[86] Murphy RX Jr, Alderman A, Gutowski K, Kerrigan C, Rohrich RJ, Byrd HS, et al. Evidence-based practices for thromboembolism prophylaxis: summary of the American Society of Plastic Surgeons Venous Thromboembolism Task Force Report. Plast Reconstr Surg. 2012;130(1):168e-175e — establishes physician-completed Caprini risk scoring as the standard for VTE prophylaxis decisions in plastic surgery, given documented unreliability of patient self-assessment.

Standard 19.1 · *Standard 19: Plastic & Cosmetic Surgery*

Guidance & Learning

GUIDANCE ASF-AMB-STD19-v3.0

WHY THIS STANDARD EXISTS

Blood clot risk after plastic surgery procedures — particularly body contouring — is genuinely well-documented, and the evidence specifically shows patients cannot reliably calculate their own risk score, with roughly a quarter of patient-completed scores leading to the wrong prophylaxis decision entirely.

The evidence: [86] Murphy RX Jr, Alderman A, Gutowski K, Kerrigan C, Rohrich RJ, Byrd HS, et al. Evidence-based practices for thromboembolism prophylaxis: summary of the American Society of Plastic Surgeons Venous Thromboembolism Task Force Report. Plast Reconstr Surg. 2012;130(1):168e-175e — establishes physician-completed Caprini risk scoring as the standard for VTE prophylaxis decisions in plastic surgery, given documented unreliability of patient self-assessment.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The VTE risk score is completed by the physician for every applicable procedure.	✗ The risk score is completed by the patient, or not completed at all.
✓ The prophylaxis decision genuinely reflects the documented risk category.	✗ Prophylaxis decisions don't consistently reflect the documented risk score.
✓ The score is reassessed if the actual procedure differs from what was planned.	✗ The score isn't reassessed even when the procedure scope changes significantly.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The score is physician-completed for major procedures but skipped for shorter or perceived lower-risk cases.**
The 60-minute general anesthesia threshold, not a subjective sense of procedure risk, is what determines whether scoring applies.

2 **The score is completed but prophylaxis decisions default to a standard approach regardless of the specific category.**
The whole value of risk stratification is lost if prophylaxis doesn't actually vary by category.

3 **Reassessment happens when the surgeon proactively remembers, without a defined trigger.**
A defined trigger provides more reliable reassessment than dependence on individual memory.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current VTE risk assessment practice for physician completion versus patient self-report.

Week 2 Establish or reinforce genuine linkage between risk category and prophylaxis decision.

Week 3 Define a specific trigger for reassessment when procedure scope changes.

Ongoing Audit risk score completion and prophylaxis decision consistency periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask specifically who completes the risk score — check for patient self-report specifically.
This is a documented, specific failure mode worth checking directly, not assuming.

Ask for a real example of a high-risk score and the resulting prophylaxis decision.
A real example reveals whether the score genuinely drives decisions, not just gets recorded.

E-LEARNING academy.gmj.ge/amb-std19-1-vte-risk-assessment — 30 min · complete before self-assessment

	Standard 19.2 NON-NEGOTIABLE · *Standard 19: Plastic & Cosmetic Surgery* **Office-Based Anesthesia Follows Defined Safety Standards**	ASSESSMENT ASF-AMB-STD19-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

19.2
NON-NEGOTIABLE
L1

THE STANDARD

Office-Based Anesthesia Follows Defined Safety Standards

Anesthesia administered in an office-based surgical setting follows the same defined safety standards as a hospital operating room — qualified personnel, appropriate monitoring equipment, and a defined emergency transfer protocol — not a reduced standard justified by the office setting.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is anesthesia administered by personnel with qualifications equivalent to a hospital operating room standard?** *The same qualification standard, not a reduced one for the office setting.* Doc: Anesthesia personnel qualification record	YES	PARTIAL	NO
2	**Is monitoring equipment equivalent to what a hospital operating room would use for the same procedure?** *Genuinely equivalent equipment, not a scaled-down version.* Doc: Monitoring equipment inventory	YES	PARTIAL	NO
3	**Is there a specific, defined emergency transfer protocol to a hospital, with a named receiving facility?** *A specific, real protocol and named facility, not a general assumption that transfer would happen if needed.* Doc: Emergency transfer protocol 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 *Personnel qualification review*	Reviews anesthesia personnel qualifications against hospital-equivalent standards.
OBSERVE *Monitoring equipment check*	Physically confirms monitoring equipment is genuinely equivalent to hospital operating room standards.
DOCUMENT *Emergency transfer protocol review*	Reviews the specific emergency transfer protocol and named receiving facility.

REFERENCES

[87] Office-based anesthesia safety standards equivalent to hospital-based operating room requirements, including qualified personnel and defined emergency transfer protocols, are established practice for reducing the documented elevated risk associated with office-based surgical anesthesia.

Standard 19.2 · *Standard 19: Plastic & Cosmetic Surgery*

Guidance & Learning

GUIDANCE ASF-AMB-STD19-v3.0

WHY THIS STANDARD EXISTS

Office-based cosmetic surgery has a documented history of serious adverse events specifically linked to inadequate anesthesia monitoring and unprepared emergency response — the setting being an office rather than a hospital doesn't reduce the real risk anesthesia carries, and the safety standard shouldn't be reduced either.

The evidence: [87] Office-based anesthesia safety standards equivalent to hospital-based operating room requirements, including qualified personnel and defined emergency transfer protocols, are established practice for reducing the documented elevated risk associated with office-based surgical anesthesia.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Anesthesia personnel meet hospital-equivalent qualification standards.	✗ Personnel qualifications are reduced relative to hospital standards, justified by the office setting.
✓ Monitoring equipment is genuinely equivalent to a hospital operating room.	✗ Monitoring equipment is a scaled-down version of what a hospital would use.
✓ A specific emergency transfer protocol exists with a named receiving facility.	✗ No specific transfer protocol exists beyond a general assumption transfer would happen if needed.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Personnel qualifications are appropriate but monitoring equipment is older or less comprehensive than current hospital standard.**
Equipment standards, not just personnel qualifications, need to genuinely match hospital equivalence.

2 **A transfer protocol exists but hasn't been tested or reviewed recently.**
An untested protocol may not translate smoothly into real action during an actual emergency.

3 **The receiving facility was named some time ago but the relationship hasn't been reconfirmed as still active.**
A relationship needs to remain genuinely active, not just historically established.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current anesthesia personnel qualifications and monitoring equipment against hospital-equivalent standards.

Week 2 Address any gap in personnel qualification or equipment equivalence.

Week 3 Establish or reconfirm a specific emergency transfer protocol with a named facility.

Ongoing Periodically reconfirm the transfer relationship remains active.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see actual monitoring equipment and compare against hospital operating room standard.
Direct physical comparison reveals whether equivalence is genuine, not assumed.

Ask for a real, recent example of the transfer protocol being used or tested.
A real example, or its honest absence, reveals whether the protocol genuinely functions.

E-LEARNING academy.gmj.ge/amb-std19-2-anesthesia-safety — 30 min · complete before self-assessment

	Standard 19.3 **NON-NEGOTIABLE** · *Standard 19: Plastic & Cosmetic Surgery* **Patient Selection Excludes Those Outside Safe Office-Based Surgery Criteria**	**ASSESSMENT** ASF-AMB-STD19-v3.0
CR N/A	**TR** FULL	**SM** FULL	**ST** FULL

19.3
NON-NEGOTIABLE
L1

THE STANDARD

Patient Selection Excludes Those Outside Safe Office-Based Surgery Criteria

Patient selection for office-based procedures follows specific, defined exclusion criteria — BMI thresholds, relevant comorbidities, combined procedure duration limits — verified before scheduling, not assessed only on the day of surgery when declining is far harder.

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

1	**Are specific exclusion criteria for office-based surgery defined and applied before scheduling, not only assessed the day of surgery?** *Pre-scheduling assessment, catching an issue before the patient has already prepared and arrived.* Doc: Pre-scheduling selection criteria document	YES	PARTIAL	NO
2	**Do the criteria specifically address BMI thresholds, relevant comorbidities, and combined procedure duration limits?** *Specific, named factors, not a general clinical judgement standard.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a real, documented example of a patient being declined or redirected to a hospital setting based on these criteria?** *A real example demonstrates the criteria have genuine teeth, not just theoretical existence.* Doc: Declined-case 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 *Pre-scheduling criteria review*	Reviews whether selection criteria are genuinely applied before scheduling, not only on the day of surgery.
DOCUMENT *Criteria specificity review*	Reviews criteria for specific coverage of BMI, comorbidities, and duration limits.
DOCUMENT *Declined-case review*	Reviews for a real, documented example of a patient declined or redirected based on the criteria.

REFERENCES

[88] Defined, pre-scheduling patient selection criteria for office-based surgical safety, distinct from same-day clinical assessment, are established practice for reducing the documented risk associated with proceeding despite contraindicating patient factors.

Standard 19.3 · *Standard 19: Plastic & Cosmetic Surgery*

Guidance & Learning

GUIDANCE ASF-AMB-STD19-v3.0

WHY THIS STANDARD EXISTS

Certain patient factors genuinely change the safety calculus of performing a procedure in an office-based setting versus a hospital, and the safest point to identify this is well before the day of surgery — assessing suitability only once the patient has already arrived, prepared, and is emotionally invested in proceeding makes an honest exclusion decision far harder to make.

The evidence: [88] Defined, pre-scheduling patient selection criteria for office-based surgical safety, distinct from same-day clinical assessment, are established practice for reducing the documented risk associated with proceeding despite contraindicating patient factors.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Selection criteria are applied before scheduling, catching issues early.	✗ Suitability is assessed only on the day of surgery, when declining is far harder.
✓ Criteria specifically address BMI, comorbidities, and duration limits.	✗ Criteria are general clinical judgement without specific, named factors.
✓ A real, documented example exists of a patient being declined or redirected.	✗ No example exists of the criteria ever actually resulting in a decline or redirection.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Criteria exist and are generally applied but aren't consistently checked before scheduling confirmation.**
The value of early assessment is lost if it happens after scheduling is already confirmed.

2 **BMI and comorbidities are considered but combined procedure duration limits aren't specifically tracked.**
Combining multiple procedures can meaningfully extend total anesthesia time beyond any single procedure's individual risk profile.

3 **The practice believes it would decline an unsuitable patient but has no real example to demonstrate this.**
An untested belief and a demonstrated, real practice are different things.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current patient selection timing against a genuine pre-scheduling standard.

Week 2 Establish specific, named exclusion criteria covering BMI, comorbidities, and duration limits.

Week 3 Build the criteria check into the scheduling process itself, before confirmation.

Ongoing Document any case where criteria result in a decline or redirection.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the specific BMI threshold and duration limit used, not a general description of careful patient selection.
Specific, named figures reveal a genuine standard rather than case-by-case judgement alone.

Ask for a real example of a declined or redirected patient.
A real example, or its honest absence, is the clearest evidence of whether criteria have genuine teeth.

E-LEARNING academy.gmj.ge/amb-std19-3-patient-selection — 30 min · complete before self-assessment

STANDARD 20

Psychiatry & Mental Health

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

3 criteria

	Standard 20.1 NON-NEGOTIABLE · *Standard 20: Psychiatry & Mental Health* **Suicide Risk Screening Uses a Validated Tool, Applied Consistently**	ASSESSMENT ASF-AMB-STD20-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

20.1
NON-NEGOTIABLE
L1

THE STANDARD

Suicide Risk Screening Uses a Validated Tool, Applied Consistently

Every patient is screened for suicide risk using a validated, unmodified screening tool, with a documented, evidence-based follow-up process for anyone who screens positive — not an informal clinical impression in place of a structured, consistent process.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every patient screened using a validated tool, administered without informal changes to its wording?** *The tool exactly as validated, not adapted or shortened informally.* Doc: Screening tool documentation	YES	PARTIAL	NO
2	**Does a positive screen trigger a defined, evidence-based follow-up assessment, not just a note in the chart?** *A genuine, structured next step, not passive documentation alone.* Doc: Follow-up assessment protocol	YES	PARTIAL	NO
3	**Is the documented risk level tied to a specific, written mitigation plan for that patient?** *A real, individual plan, not a generic statement that risk was assessed.* Doc: Risk level and mitigation plan 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 *Screening tool review*	Reviews the screening tool used for validation status and confirms it's administered without informal modification.
DOCUMENT *Follow-up protocol review*	Reviews the defined follow-up process for patients who screen positive.
DOCUMENT *Mitigation plan review*	Reviews documentation linking risk level to a specific, individual mitigation plan.

REFERENCES

[89] Established patient safety guidance on reducing the risk for suicide requires validated-tool screening for behavioral health patients, an evidence-based follow-up process for positive screens, and documented risk level with a written mitigation plan.

Standard 20.1 · *Standard 20: Psychiatry & Mental Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD20-v3.0

WHY THIS STANDARD EXISTS

An informal impression of risk, however well-intentioned, is measurably less reliable than a validated tool applied consistently — and consistency itself matters, since even small, informal changes to a validated tool's wording have been shown to affect its accuracy.

The evidence: [89] Established patient safety guidance on reducing the risk for suicide requires validated-tool screening for behavioral health patients, an evidence-based follow-up process for positive screens, and documented risk level with a written mitigation plan.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A validated tool is used consistently, without informal modification.	✗ Screening relies on informal clinical impression rather than a validated tool.
✓ A positive screen triggers a defined, evidence-based follow-up assessment.	✗ A positive screen isn't followed by any defined next step.
✓ Risk level is tied to a specific, written, individual mitigation plan.	✗ Risk is documented without any specific, individual mitigation plan attached.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The tool is used consistently but staff have informally shortened some questions to save time.**
Even small wording changes have been shown to affect a validated tool's accuracy.

2 **Follow-up happens for clearly positive screens but is less consistent for borderline results.**
A consistent, defined threshold protects against inconsistent judgement calls.

3 **A mitigation plan exists but isn't reviewed or updated at subsequent visits.**
Risk can change over time, and a plan needs to reflect the patient's current situation, not only their status at first assessment.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Confirm the screening tool used is validated and administered without informal modification.

Week 2 Establish or reinforce a defined, evidence-based follow-up process for positive screens.

Week 3 Ensure every documented risk level is tied to a specific, individual mitigation plan.

Ongoing Review and update mitigation plans at subsequent visits.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the exact screening tool used and confirm it matches the validated version, unmodified.
Direct comparison is the only way to confirm the tool hasn't been informally altered.

Ask staff to describe the specific follow-up process for a positive screen.
A specific, confident answer reveals a genuine, defined process rather than case-by-case judgement.

E-LEARNING academy.gmj.ge/amb-std20-1-risk-screening — 30 min · complete before self-assessment

	Standard 20.2 **NON-NEGOTIABLE** · *Standard 20: Psychiatry & Mental Health* **Psychiatric Medication Management Follows a Defined Interaction and Monitoring Protocol**	**ASSESSMENT** ASF-AMB-STD20-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

20.2
NON-NEGOTIABLE
L1

THE STANDARD

Psychiatric Medication Management Follows a Defined Interaction and Monitoring Protocol

Psychiatric medication prescribing follows a defined process for checking interactions specific to psychotropic combinations, with required baseline and ongoing monitoring completed and reviewed — not prescribed based on symptom response alone, without the monitoring psychotropic medications specifically require.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a defined process for checking interactions specific to psychotropic medication combinations?** *A specific process for this medication class, not general interaction checking alone.* Doc: Psychotropic interaction checking protocol	YES	PARTIAL	NO
2	**Is required baseline monitoring completed before starting medications that specifically require it?** *Genuine baseline testing before starting, not added only if a concern later emerges.* Doc: Baseline monitoring record	YES	PARTIAL	NO
3	**Is ongoing monitoring completed and reviewed at the required intervals, not only at symptom-focused visits?** *A defined, followed monitoring schedule, distinct from routine symptom check-ins.* Doc: Ongoing monitoring schedule and review 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 *Interaction checking protocol review*	Reviews the specific process for checking psychotropic medication interactions.
DOCUMENT *Baseline monitoring review*	Reviews records confirming required baseline monitoring is completed before starting relevant medications.
DOCUMENT *Ongoing monitoring review*	Reviews adherence to the required ongoing monitoring schedule.

REFERENCES

[90] Defined interaction checking and required baseline and ongoing monitoring specific to psychotropic medication classes, distinct from general medication safety practice, is established practice in psychiatric prescribing safety literature.

Standard 20.2 · *Standard 20: Psychiatry & Mental Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD20-v3.0

WHY THIS STANDARD EXISTS

Psychotropic medications carry interaction and monitoring requirements that are genuinely distinct from general prescribing safety — certain combinations carry real, specific risk, and several classes require baseline and ongoing laboratory monitoring that symptom improvement alone doesn't substitute for.

The evidence: [90] Defined interaction checking and required baseline and ongoing monitoring specific to psychotropic medication classes, distinct from general medication safety practice, is established practice in psychiatric prescribing safety literature.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific process checks interactions for psychotropic combinations.	✗ Interaction checking doesn't specifically address psychotropic combinations.
✓ Required baseline monitoring is genuinely completed before starting relevant medications.	✗ Baseline monitoring is skipped or added only after a concern arises.
✓ Ongoing monitoring is completed and reviewed at required intervals.	✗ Ongoing monitoring lapses or isn't reviewed even when technically completed.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Interaction checking happens for new prescriptions but isn't rechecked when a second psychotropic medication is added later.**
Interaction risk applies at the point combinations actually occur, not only at initial prescribing.

2 **Baseline monitoring is completed but results aren't reviewed before the medication is actually started.**
A completed test that isn't reviewed before prescribing doesn't provide the intended protection.

3 **Ongoing monitoring is scheduled but appointments are sometimes missed without a specific follow-up process.**
A monitoring schedule needs a defined response when it isn't met, not silent gaps.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current interaction checking practice for psychotropic-specific coverage.

Week 2 Establish or verify required baseline monitoring completion before starting relevant medications.

Week 3 Establish a defined ongoing monitoring schedule with a specific follow-up process for missed appointments.

Ongoing Audit monitoring completion and review against the required schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask what specific baseline monitoring is required for a commonly prescribed psychotropic medication here.
A specific, correct answer reveals genuine, current knowledge of monitoring requirements.

Ask what happens when a patient misses a required monitoring appointment.
A specific, defined answer reveals whether this is genuinely tracked, not passively hoped for.

E-LEARNING academy.gmj.ge/amb-std20-2-medication-monitoring — 30 min · complete before self-assessment

	Standard 20.3 **NON-NEGOTIABLE** · *Standard 20: Psychiatry & Mental Health* **Crisis Escalation Has a Defined, Immediate Pathway to Higher Level of Care**	**ASSESSMENT** ASF-AMB-STD20-v3.0

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

20.3
NON-NEGOTIABLE
L1

THE STANDARD

Crisis Escalation Has a Defined, Immediate Pathway to Higher Level of Care

Staff have a defined, immediate escalation pathway for a patient in acute crisis, with a specific, named receiving facility for emergency psychiatric care, verified as genuinely functioning — not a general understanding that emergency services would be contacted if needed.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific, defined escalation pathway for a patient in acute crisis, not general awareness that help exists?** *A specific, known pathway, not improvisation in the moment.* Doc: Crisis escalation protocol document	YES	PARTIAL	NO
2	**Is there a specific, named receiving facility for emergency psychiatric care?** *A specific facility and relationship, not a general assumption somewhere would take the patient.* Doc: Named receiving facility documentation	YES	PARTIAL	NO
3	**Do all clinical staff, not only the most senior, know the specific escalation steps 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 *Escalation pathway review*	Reviews the specific, defined escalation pathway for completeness.
DOCUMENT *Receiving facility review*	Reviews the specific, named receiving facility relationship for emergency psychiatric care.
ASK *Staff readiness interview*	Asks a range of staff, not only the most senior, to describe the escalation pathway.

REFERENCES

[91] A defined, verified escalation pathway to emergency psychiatric care, distinct from general awareness that emergency services exist, is established practice in outpatient behavioral health crisis management.

Standard 20.3 · *Standard 20: Psychiatry & Mental Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD20-v3.0

WHY THIS STANDARD EXISTS

A crisis situation requires an immediate, practiced response, and the time to work out how escalation actually happens is not during the crisis itself — a specific, verified pathway removes uncertainty from exactly the moment uncertainty is most dangerous.

The evidence: [91] A defined, verified escalation pathway to emergency psychiatric care, distinct from general awareness that emergency services exist, is established practice in outpatient behavioral health crisis management.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, defined escalation pathway exists for acute crisis.	✗ No specific pathway exists beyond general awareness that emergency services could be contacted.
✓ A specific, named receiving facility relationship is confirmed and active.	✗ No specific receiving facility is named, only a general assumption.
✓ All clinical staff, not just the most senior, know the pathway confidently.	✗ Only the most senior staff member present is confident in the escalation process.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The pathway is well understood by the primary psychiatrist but less consistently by other clinical staff.**
A crisis can be first recognised by any staff member present, not only the psychiatrist.

2 **A receiving facility relationship exists but hasn't been reconfirmed as active recently.**
Relationships can lapse without either party actively noticing.

3 **The pathway is known but has never been rehearsed as an actual drill.**
A rehearsed response is more reliable under real, high-pressure conditions than a policy read once.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current crisis escalation practice for a specific, defined pathway.

Week 2 Confirm or establish a specific, named receiving facility relationship.

Week 3 Brief all clinical staff, not only senior staff, on the specific escalation steps.

Ongoing Periodically reconfirm the receiving facility relationship remains active.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a non-senior staff member to describe the escalation pathway.
This reveals whether readiness is genuinely distributed, not concentrated in one person.

Ask for a real, recent example of the pathway being used, or a genuine drill.
A real example, or its honest absence, reveals whether this pathway genuinely functions under real conditions.

E-LEARNING academy.gmj.ge/amb-std20-3-crisis-escalation — 30 min · complete before self-assessment

STANDARD 21

Narcology & Addiction Treatment

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

3 criteria

Standard 21.1 **NON-NEGOTIABLE** · *Standard 21: Narcology & Addiction Treatment*

Controlled Substance Handling Follows a Defined Diversion Control Plan

ASSESSMENT ASF-AMB-STD21-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

21.1
NON-NEGOTIABLE
L1

THE STANDARD

Controlled Substance Handling Follows a Defined Diversion Control Plan

Storage, dispensing, and any take-home provision of controlled medications used in addiction treatment follows a specific, written diversion control plan — secure storage, dispensing records, identifiable take-home packaging — not general good practice without a defined, documented plan.

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

1	**Is there a specific, written diversion control plan covering storage, dispensing, and take-home provision?** *A specific, documented plan, not general good practice assumed to be sufficient.* Doc: Diversion control plan document	YES	PARTIAL	NO
2	**Is take-home medication packaged and labeled in a way specifically designed to identify it and deter diversion?** *Specific, identifiable packaging, not standard containers without distinguishing features.* Doc: Take-home packaging protocol	YES	PARTIAL	NO
3	**Do patients receiving take-home medication receive specific education on safe storage and transport, including household safety?** *Genuine, documented education, not assumed common sense.* Doc: Patient education 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 *Diversion control plan review*	Reviews the written diversion control plan for specificity and completeness.
OBSERVE *Take-home packaging check*	Confirms take-home medication packaging is specifically identifiable and secure.
DOCUMENT *Patient education review*	Reviews documentation of specific patient education on safe storage and transport.

REFERENCES

[92] Established regulatory principles for medications used in the treatment of opioid use disorder, recognized in various forms across many countries, require a written diversion control plan, secure and identifiable take-home medication packaging, and patient education on safe storage and transport.

Standard 21.1 · *Standard 21: Narcology & Addiction Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD21-v3.0

WHY THIS STANDARD EXISTS

Controlled medications used in addiction treatment carry real diversion risk precisely because they are effective, sought-after substances, and a defined, written plan — not general care — is what specifically prevents theft, diversion, and unsafe handling at each stage from storage through to the patient's own home.

The evidence: [92] Established regulatory principles for medications used in the treatment of opioid use disorder, recognized in various forms across many countries, require a written diversion control plan, secure and identifiable take-home medication packaging, and patient education on safe storage and transport.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, written diversion control plan covers storage, dispensing, and take-home provision.	✗ No specific written plan exists beyond general good practice.
✓ Take-home packaging is specifically identifiable and secure.	✗ Take-home packaging isn't specifically identifiable or secure.
✓ Patients receive genuine, documented education on safe storage and transport.	✗ Patient education on storage and transport is assumed rather than genuinely provided.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Storage security is strong but dispensing records aren't consistently reconciled against inventory.**
Diversion can occur at the dispensing stage even when storage itself is secure.

2 **Take-home packaging is used but doesn't consistently include identifying information.**
Identifiable packaging is specifically what allows recovery or accountability if diversion is suspected.

3 **Education happens for new patients but isn't reinforced for those on long-term take-home regimens.**
Household circumstances can change over the course of long-term treatment, and reinforcement matters.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current controlled substance handling against a specific, written diversion control plan standard.

Week 2 Establish or strengthen identifiable, secure take-home packaging.

Week 3 Establish genuine, documented patient education on safe storage and transport.

Ongoing Reconcile dispensing records against inventory regularly.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual written diversion control plan, not a general description of careful handling.
A specific, written document is the real evidence of a genuine plan.

Ask a patient receiving take-home medication what storage guidance they were given.
This reveals whether education is genuine practice, not just assumed to have happened.

E-LEARNING academy.gmj.ge/amb-std21-1-diversion-control — 30 min · complete before self-assessment

	Standard 21.2 **NON-NEGOTIABLE** · *Standard 21: Narcology & Addiction Treatment* **Withdrawal Management Uses a Validated Assessment Scale, Not Clinical Impression Alone**	**ASSESSMENT** ASF-AMB-STD21-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

21.2
NON-NEGOTIABLE
L1

THE STANDARD

Withdrawal Management Uses a Validated Assessment Scale, Not Clinical Impression Alone

Withdrawal severity is assessed using a validated, standardised scale, applied consistently and at defined intervals, with the result actively guiding the management decision — not estimated from clinical impression without a structured, repeatable tool.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a validated, standardised withdrawal assessment scale used consistently, not clinical impression alone?** *A specific, validated tool, applied the same way every time.* Doc: Withdrawal assessment scale documentation	YES	PARTIAL	NO
2	**Is the scale applied at defined intervals appropriate to the withdrawal risk, not only when a concern happens to arise?** *A specific, scheduled interval, not reactive assessment alone.* Doc: Assessment interval protocol	YES	PARTIAL	NO
3	**Does the scale result actually guide the management decision, not just get recorded alongside a separately made clinical decision?** *Genuine, documented linkage between score and decision, not parallel, disconnected processes.* Doc: Score-to-decision linkage 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 *Assessment scale review*	Reviews the specific validated scale used and confirms consistent application.
DOCUMENT *Assessment interval review*	Reviews the defined interval schedule for withdrawal assessment.
DOCUMENT *Score-to-decision review*	Reviews whether management decisions are genuinely linked to the assessment score.

REFERENCES

[93] Sullivan JT, Sykora K, Schneiderman J, Naranjo CA, Sellers EM. Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). Br J Addict. 1989;84(11):1353-1357 — establishes a validated, standardised scale for withdrawal severity assessment, widely adopted as the clinical standard.

Standard 21.2 · *Standard 21: Narcology & Addiction Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD21-v3.0

WHY THIS STANDARD EXISTS

Withdrawal severity can escalate significantly within a short period, and a validated, standardised scale gives a consistent, comparable measurement over time that clinical impression alone cannot reliably provide — this consistency is what allows genuinely early recognition of escalating severity.

The evidence: [93] Sullivan JT, Sykora K, Schneiderman J, Naranjo CA, Sellers EM. Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). Br J Addict. 1989;84(11):1353-1357 — establishes a validated, standardised scale for withdrawal severity assessment, widely adopted as the clinical standard.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A validated scale is used consistently for every applicable patient.	✗ Withdrawal severity is estimated from clinical impression without a structured tool.
✓ Assessment happens at defined, scheduled intervals.	✗ Assessment happens only reactively, when a concern arises.
✓ Management decisions are genuinely and documentably linked to the score.	✗ Scores are recorded but don't genuinely drive the management decision made.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The scale is used consistently during standard hours but less consistently during off-hours coverage.**
Withdrawal risk doesn't diminish outside standard operating hours.

2 **Assessment intervals are followed initially but relax as a patient's condition appears to stabilise.**
Early stabilisation doesn't eliminate the value of continued, consistent monitoring.

3 **The score is calculated correctly but the specific threshold for changing management isn't clearly defined.**
A calculated score without a clear action threshold provides limited real guidance.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current withdrawal assessment practice for validated scale use versus clinical impression alone.

Week 2 Establish or reinforce a defined assessment interval schedule.

Week 3 Define clear thresholds linking specific scores to specific management decisions.

Ongoing Audit consistency of scale use across all coverage periods, including off-hours.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff working off-hours or covering shifts specifically about assessment practice.
This is where consistency most commonly relaxes relative to standard hours.

Ask for a specific example of a score change leading to a specific management change.
A real example reveals whether the score genuinely drives decisions, not just gets recorded.

E-LEARNING academy.gmj.ge/amb-std21-2-withdrawal-assessment — 30 min · complete before self-assessment

	Standard 21.3 **CORE** · *Standard 21: Narcology & Addiction Treatment* **Urine Drug Screening Chain of Custody Prevents Tampering**	**ASSESSMENT** ASF-AMB-STD21-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

21.3
CORE
L1

THE STANDARD

Urine Drug Screening Chain of Custody Prevents Tampering

Urine drug screening follows a defined chain-of-custody process — specimen temperature verification, direct observation where clinically indicated, secure transport — that genuinely prevents substitution or tampering, not a process that assumes good faith without verification.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is specimen temperature verified immediately after collection, as a specific, documented step?** *A specific, documented check, not assumed from general collection procedure.* Doc: Temperature verification record	YES	PARTIAL	NO
2	**Is direct observation used where clinically indicated, following a specific, defined standard for when it applies?** *A specific standard for when observation is used, not inconsistent, ad hoc application.* Doc: Direct observation policy	YES	PARTIAL	NO
3	**Is chain of custody maintained and documented from collection through to result, with any break specifically flagged?** *A genuinely unbroken, documented chain, with any gap specifically identified, not assumed intact.* Doc: Chain of custody 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 *Temperature verification review*	Reviews records confirming specimen temperature is verified immediately after collection.
DOCUMENT *Direct observation policy review*	Reviews the specific standard for when direct observation is clinically indicated and applied.
DOCUMENT *Chain of custody review*	Reviews documentation for a genuinely unbroken chain of custody from collection to result.

REFERENCES

[94] Specimen temperature verification and defined chain-of-custody procedures are established practice for preventing urine drug screening substitution and tampering in addiction treatment settings.

Standard 21.3 · *Standard 21: Narcology & Addiction Treatment*

Guidance & Learning

GUIDANCE ASF-AMB-STD21-v3.0

WHY THIS STANDARD EXISTS

A drug screening result that can be substituted or tampered with provides false reassurance that's arguably worse than no test at all, since it creates confidence in a result that doesn't reflect reality — the verification steps exist specifically because good faith alone hasn't proven sufficient.

The evidence: [94] Specimen temperature verification and defined chain-of-custody procedures are established practice for preventing urine drug screening substitution and tampering in addiction treatment settings.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Specimen temperature is verified and documented immediately after collection.	✗ Temperature verification doesn't happen or isn't documented.
✓ Direct observation follows a specific, defined standard, applied consistently.	✗ Direct observation is applied inconsistently without a clear standard.
✓ Chain of custody is genuinely unbroken and documented, with any gap specifically flagged.	✗ Chain of custody has undocumented gaps or is assumed intact without verification.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Temperature verification happens but isn't consistently documented in the specimen record.**
An undocumented check is difficult to distinguish from a check that didn't happen.

2 **Direct observation criteria exist but aren't consistently applied by all staff collecting specimens.**
A standard needs consistent application across everyone performing collection to provide real protection.

3 **Chain of custody documentation exists but has occasional gaps during transport to an external lab.**
Any gap in the chain, however brief, represents a real point where tampering could occur undetected.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current specimen collection practice for temperature verification and documentation.

Week 2 Establish or reinforce a specific, consistently applied direct observation standard.

Week 3 Close any gap in chain-of-custody documentation, particularly during external transport.

Ongoing Audit chain-of-custody documentation for completeness periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual temperature verification and chain-of-custody documentation for a recent specimen.
Specific, dated records are the only real evidence of a genuinely functioning process.

Ask staff the specific criteria for when direct observation is used.
A specific, consistent answer reveals a genuine standard rather than inconsistent individual judgement.

E-LEARNING academy.gmj.ge/amb-std21-3-drug-screening-custody — 30 min · complete before self-assessment

STANDARD 22

Gastroenterology & Endoscopy

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

3 criteria

Standard 22.1 **NON-NEGOTIABLE** · *Standard 22: Gastroenterology & Endoscopy*

Endoscope Reprocessing Follows the Multisociety Guideline, With Documented Staff Competency

ASSESSMENT ASF-AMB-STD22-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

22.1
NON-NEGOTIABLE
L1

THE STANDARD

Endoscope Reprocessing Follows the Multisociety Guideline, With Documented Staff Competency

Flexible endoscope reprocessing follows the current multisociety guideline in full — cleaning before high-level disinfection, model-specific manufacturer instructions, complete documentation of every step — with staff competency specifically assessed and documented before they are permitted to perform reprocessing independently.

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

1	**Does reprocessing follow a written policy matching the current multisociety guideline, including model-specific manufacturer instructions?** *A specific, current, written policy, not general infection-control practice assumed to be sufficient.* Doc: Reprocessing policy document	YES	PARTIAL	NO
2	**Is staff competency specifically assessed and documented before they perform reprocessing independently?** *Assessed competency before independent practice, not assumed from general training.* Doc: Staff competency assessment record	YES	PARTIAL	NO
3	**Is every reprocessing step documented for every instrument, creating a genuine, traceable record?** *Complete, traceable documentation, not partial or assumed record-keeping.* Doc: Reprocessing step 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 *Reprocessing policy review*	Reviews the written reprocessing policy against the current multisociety guideline.
DOCUMENT *Staff competency review*	Reviews competency assessment records for every staff member performing reprocessing.
DOCUMENT *Step documentation review*	Reviews reprocessing records for complete, traceable documentation of every step.

REFERENCES

[95] Day LW, Muthusamy VR, Collins J, Kushnir VM, Sultan S, Pannala R, et al. Multisociety guideline on reprocessing flexible GI endoscopes and accessories. Gastrointest Endosc. 2021;93(1):11-33 — requires a written reprocessing policy, model-specific manufacturer training, and documented staff competency prior to independent performance of high-level disinfection or sterilization.

Standard 22.1 · *Standard 22: Gastroenterology & Endoscopy*

Guidance & Learning

GUIDANCE ASF-AMB-STD22-v3.0

WHY THIS STANDARD EXISTS

Endoscope reprocessing failure is one of the most well-documented healthcare-associated infection risks in ambulatory medicine, and the evidence specifically shows that staff competency has to be verified before independent practice begins, not assumed from general training or experience with other equipment.

The evidence: [95] Day LW, Muthusamy VR, Collins J, Kushnir VM, Sultan S, Pannala R, et al. Multisociety guideline on reprocessing flexible GI endoscopes and accessories. Gastrointest Endosc. 2021;93(1):11-33 — requires a written reprocessing policy, model-specific manufacturer training, and documented staff competency prior to independent performance of high-level disinfection or sterilization.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The written policy matches the current multisociety guideline, including model-specific instructions.	✗ The policy is outdated or doesn't reflect model-specific manufacturer instructions.
✓ Staff competency is specifically assessed and documented before independent practice.	✗ Staff perform reprocessing without documented, assessed competency.
✓ Every reprocessing step is documented, creating a genuine, traceable record.	✗ Reprocessing documentation is partial or assumed rather than genuinely complete.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Competency was assessed at hiring but hasn't been reassessed as new endoscope models were introduced.**
Model-specific competency needs to reflect the actual equipment currently in use, not only equipment used at initial training.

2 **Documentation is complete for the disinfection step but less consistent for the initial cleaning step.**
Cleaning before disinfection is itself a critical, distinct step the guideline specifically requires be documented.

3 **The policy exists but wasn't updated when the current multisociety guideline was last revised.**
A guideline that's periodically revised requires the facility's own policy to be periodically reconfirmed against it.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current reprocessing policy against the current multisociety guideline in full.

Week 2 Establish or verify documented competency assessment for every staff member, specific to equipment currently in use.

Week 3 Confirm complete, traceable documentation exists for every reprocessing step.

Ongoing Reassess competency whenever new endoscope models are introduced.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual competency assessment record for a specific staff member.
A specific, documented record is the only real evidence competency was genuinely verified, not assumed.

Ask whether the policy has been reviewed since the guideline was last revised.
This reveals whether the facility's practice stays genuinely current, not just historically compliant.

E-LEARNING academy.gmj.ge/amb-std22-1-endoscope-reprocessing — 30 min · complete before self-assessment

	Standard 22.2 NON-NEGOTIABLE · *Standard 22: Gastroenterology & Endoscopy* **Procedural Sedation Monitoring Follows Defined Standards**	ASSESSMENT ASF-AMB-STD22-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

22.2
NON-NEGOTIABLE
L1

THE STANDARD

Procedural Sedation Monitoring Follows Defined Standards

Patients receiving procedural sedation for endoscopy are monitored using continuous pulse oximetry and capnography, with vital signs recorded at defined intervals and specific, defined discharge criteria met before release — not monitored informally or released based on general appearance alone.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is continuous pulse oximetry and capnography used for every patient receiving procedural sedation?** *Continuous, objective monitoring, not periodic spot-checking.* Doc: Sedation monitoring protocol	YES	PARTIAL	NO
2	**Are vital signs recorded at defined intervals throughout the procedure and recovery, not only at the start and end?** *Consistent, scheduled recording throughout, not concentrated at the edges.* Doc: Vital signs recording log	YES	PARTIAL	NO
3	**Are specific, defined discharge criteria met and documented before a patient is released, not judged from general appearance?** *A specific, validated criteria set, not a subjective impression the patient seems ready.* Doc: Discharge criteria 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 *Monitoring practice observation*	Observes actual sedation monitoring for continuous pulse oximetry and capnography use.
DOCUMENT *Vital signs recording review*	Reviews recording logs for defined-interval consistency throughout procedure and recovery.
DOCUMENT *Discharge criteria review*	Reviews documentation confirming specific discharge criteria were met before release.

REFERENCES

[96] Continuous pulse oximetry and capnography monitoring during procedural sedation, combined with specific, validated discharge criteria, are established practice in ambulatory endoscopy safety guidelines for detecting sedation-related respiratory compromise.

Standard 22.2 · *Standard 22: Gastroenterology & Endoscopy*

Guidance & Learning

GUIDANCE ASF-AMB-STD22-v3.0

WHY THIS STANDARD EXISTS

Procedural sedation carries genuine risk of respiratory depression that can develop gradually and be difficult to detect through observation alone — continuous, objective monitoring specifically catches this earlier than periodic checking or visual assessment can.

The evidence: [96] Continuous pulse oximetry and capnography monitoring during procedural sedation, combined with specific, validated discharge criteria, are established practice in ambulatory endoscopy safety guidelines for detecting sedation-related respiratory compromise.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Continuous pulse oximetry and capnography are used for every sedated patient.	✗ Monitoring is periodic or informal rather than continuous and objective.
✓ Vital signs are recorded at defined intervals throughout procedure and recovery.	✗ Vital signs are recorded only at the start and end, with gaps during the procedure.
✓ Specific, defined discharge criteria are met and documented before release.	✗ Discharge is based on general appearance rather than specific, documented criteria.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Pulse oximetry is used consistently but capnography is used only for higher-sedation-level cases.**
Capnography detects respiratory compromise earlier than pulse oximetry alone, at any sedation level.

2 **Vital signs recording is thorough during the procedure but less consistent during recovery.**
Sedation-related complications can develop during recovery, not only during the procedure itself.

3 **Discharge criteria exist but aren't consistently documented as having been checked for each patient.**
Undocumented criteria checking is difficult to distinguish from criteria not genuinely being applied.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current sedation monitoring practice for continuous, objective monitoring use.

Week 2 Extend capnography use to all sedation levels if not already standard.

Week 3 Establish consistent vital signs recording throughout both procedure and recovery.

Ongoing Audit discharge criteria documentation for every sedated patient.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe actual sedation monitoring during a procedure if timing allows.
Direct observation reveals whether monitoring is genuinely continuous, not just described as such.

Ask for the specific discharge criteria used and check documentation for a recent patient.
A specific, checkable record is the real evidence discharge decisions are criteria-based, not impression-based.

E-LEARNING academy.gmj.ge/amb-std22-2-sedation-monitoring — 30 min · complete before self-assessment

	Standard 22.3 NON-NEGOTIABLE · *Standard 22: Gastroenterology & Endoscopy* **Biopsy and Polyp Specimens Are Tracked to a Confirmed Pathology Result**	ASSESSMENT ASF-AMB-STD22-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

22.3
NON-NEGOTIABLE
L1

THE STANDARD

Biopsy and Polyp Specimens Are Tracked to a Confirmed Pathology Result

Every biopsy or removed polyp specimen is tracked from collection through to a confirmed, communicated pathology result, with a specific, named process ensuring no specimen result goes unreviewed or unreported to the patient — distinct from, and more specifically tracked than, general test results.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific, named tracking process for biopsy and polyp specimens, distinct from general test result tracking?** *A dedicated process specifically for these specimens, given the distinct severity risk.* Doc: Specimen tracking log	YES	PARTIAL	NO
2	**Is there a way to identify a specimen whose result was never actually received or reviewed?** *An active mechanism that surfaces a gap, not one that only shows completed results.* Doc: Uncollected result identification process	YES	PARTIAL	NO
3	**Is the confirmed result specifically communicated to the patient, with the communication itself tracked?** *Tracked communication, not an assumption the patient was informed because the result exists in the chart.* Doc: Patient communication 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 *Specimen tracking log review*	Reviews the specific specimen tracking log for completeness from collection to confirmed result.
OBSERVE *Uncollected result identification check*	Checks whether the tracking system can actually surface a specimen whose result was never received.
DOCUMENT *Patient communication tracking review*	Reviews evidence that result communication to the patient is itself tracked, not assumed.

REFERENCES

[97] Failure to track biopsy and polypectomy specimens to a confirmed, communicated pathology result is identified as a specific and serious contributor to delayed colorectal cancer diagnosis in endoscopy patient safety literature, distinct in severity from general diagnostic test follow-up.

Standard 22.3 · *Standard 22: Gastroenterology & Endoscopy*

Guidance & Learning

GUIDANCE ASF-AMB-STD22-v3.0

WHY THIS STANDARD EXISTS

A missed or delayed pathology result on a colorectal polyp carries a specific, serious risk of delayed cancer diagnosis, and the interval between colonoscopy and definitive pathology review is exactly the point where a specimen can be lost from active tracking without anyone noticing.

The evidence: [97] Failure to track biopsy and polypectomy specimens to a confirmed, communicated pathology result is identified as a specific and serious contributor to delayed colorectal cancer diagnosis in endoscopy patient safety literature, distinct in severity from general diagnostic test follow-up.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, dedicated specimen tracking process exists, distinct from general results. ✓ The system can identify and surface a specimen whose result was never received. ✓ Patient communication of the result is itself tracked, not assumed.	✗ Specimens are tracked only within a general test-result system, with no distinct process. ✗ There is no way to identify a specimen that fell through the cracks. ✗ Communication to the patient is assumed but not actually tracked.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Tracking exists for specimens collected by the primary gastroenterologist but not consistently for those collected by covering staff.**
Every specimen carries the same real risk, regardless of who performed the procedure.

2 **The tracking log exists but isn't reviewed on a regular schedule to catch gaps.**
A log that isn't actively reviewed provides limited real protection against a missed result.

3 **Results are tracked internally but patient communication specifically isn't logged.**
An internally reviewed result that never reaches the patient still represents the failure this criterion exists to prevent.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current specimen tracking practice for a specific, dedicated process.

Week 2 Establish a tracking log covering every specimen from collection to confirmed, communicated result.

Week 3 Build a mechanism to actively surface any specimen without a received result.

Ongoing Review the tracking log on a regular schedule for gaps.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual tracking log and pick a specific, older specimen to trace through it.
Tracing a real, specific case reveals whether the system genuinely works, not just whether it exists.

Ask specifically about specimens collected during procedures performed by covering staff.
This is where tracking most commonly shows real gaps.

E-LEARNING academy.gmj.ge/amb-std22-3-specimen-tracking — 30 min · complete before self-assessment

STANDARD 23

Pediatric Ambulatory Care

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

3 criteria

Standard 23.1 **NON-NEGOTIABLE** · *Standard 23: Pediatric Ambulatory Care*

Weight-Based Dosing Uses an Accurate, Current Weight, Independently Verified

ASSESSMENT ASF-AMB-STD23-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

23.1
NON-NEGOTIABLE
L1

THE STANDARD

Weight-Based Dosing Uses an Accurate, Current Weight, Independently Verified

Every weight-based medication dose is calculated from a current, accurately measured weight — not an estimated, parent-reported, or outdated weight — with the calculation itself independently verified by a second trained person before administration.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every weight-based dose calculated from a weight measured at this visit, not estimated or carried over from a prior visit?** *A current, actually measured weight, not an estimate or an assumption it hasn't changed.* Doc: Weight measurement record	YES	PARTIAL	NO
2	**Is the dose calculation independently verified by a second trained person before administration?** *Genuine, independent verification, not the same person confirming their own calculation.* Doc: Independent dose verification record	YES	PARTIAL	NO
3	**Is there a specific, defined process if the calculated dose falls outside an expected range for the child's age or weight?** *A specific, known response, not proceeding regardless because the calculation was technically completed.* Doc: Out-of-range dose 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 *Weight measurement review*	Reviews records confirming weight-based doses use a weight measured at the current visit.
OBSERVE *Independent verification observation*	Observes an actual dose calculation for genuine, independent second-person verification.
ASK *Out-of-range response interview*	Asks staff what happens when a calculated dose falls outside the expected range.

REFERENCES

[98] Institute for Safe Medication Practices. 2025-2026 Targeted Medication Safety Best Practices for Community Pharmacy. Horsham (PA): ISMP; 2025 — specifically addresses obtaining and using an accurate, current patient weight to verify weight-based medication dosing, applicable to medical offices and clinics.

Standard 23.1 · *Standard 23: Pediatric Ambulatory Care*

Guidance & Learning

GUIDANCE ASF-AMB-STD23-v3.0

WHY THIS STANDARD EXISTS

Weight-based dosing is one of the most well-documented, specific sources of preventable pediatric medication error, precisely because a child's weight changes frequently and a small error in the weight used, or in the calculation itself, can translate directly into a meaningfully wrong dose.

The evidence: [98] Institute for Safe Medication Practices. 2025-2026 Targeted Medication Safety Best Practices for Community Pharmacy. Horsham (PA): ISMP; 2025 — specifically addresses obtaining and using an accurate, current patient weight to verify weight-based medication dosing, applicable to medical offices and clinics.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every weight-based dose uses a weight measured at the current visit.	✗ Weight is estimated, parent-reported, or carried over from a prior visit without remeasurement.
✓ Dose calculations are genuinely, independently verified by a second trained person.	✗ Verification, if it happens, isn't genuinely independent.
✓ A specific, known response exists for a dose falling outside the expected range.	✗ No specific process exists for an out-of-range calculated dose.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Weight is measured at every visit but independent verification is inconsistent for lower-risk medications.**
The weight-based calculation itself carries the same real risk regardless of the specific medication's perceived risk level.

2 **Verification happens but the second person reviews the same source information rather than calculating independently.**
Genuine independence requires a separate calculation, not confirmation of the same numbers already entered.

3 **An out-of-range threshold exists but isn't consistently applied by all staff.**
Consistent application across everyone involved in dosing is what gives the threshold real protective value.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current weight measurement practice for consistency at every visit.

Week 2 Establish genuine, independent second-person dose verification for all weight-based medications.

Week 3 Define a specific out-of-range response threshold and process.

Ongoing Audit verification genuineness and out-of-range response adherence periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual weight measurement and confirm it matches the visit date, not an earlier one.
Specific, dated records are the only real evidence the weight is genuinely current.

Ask the second verifier to describe their own independent calculation, not just confirm the first.
This reveals whether verification is genuinely independent or a formality.

E-LEARNING academy.gmj.ge/amb-std23-1-weight-based-dosing — 30 min · complete before self-assessment

	Standard 23.2 **NON-NEGOTIABLE** · *Standard 23: Pediatric Ambulatory Care* **Consent and Communication Are Structured for the Actual Decision-Maker**	**ASSESSMENT** ASF-AMB-STD23-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

23.2
NON-NEGOTIABLE
L1

THE STANDARD

Consent and Communication Are Structured for the Actual Decision-Maker

Consent and key clinical communication are directed to the parent or legal guardian as the actual decision-maker, verified as the correct individual for this specific child, with age-appropriate communication to the child themselves as a distinct, additional step — not assumed from whoever accompanies the child to the visit.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the legal decision-making authority of the accompanying adult specifically verified, not assumed?** *Genuine verification, not an assumption based on who happens to be present.* Doc: Decision-maker verification record	YES	PARTIAL	NO
2	**Is there a specific process for situations where the accompanying adult may not hold full decision-making authority?** *A known, specific process, not uncertainty about how to proceed.* Doc: Non-parent accompaniment protocol	YES	PARTIAL	NO
3	**Does the child receive age-appropriate communication about their own care, distinct from parental consent?** *A genuine, separate step for the child, not consent obtained from the parent alone with the child excluded from the conversation entirely.* 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 *Decision-maker verification review*	Reviews records for evidence that decision-making authority is specifically verified, not assumed.
DOCUMENT *Non-parent protocol review*	Reviews the specific process for situations involving a non-parent accompanying adult.
OBSERVE *Child communication observation*	Observes whether age-appropriate communication to the child happens as a distinct step.

REFERENCES

[99] Verification of legal decision-making authority, distinct from assumed authority based on who accompanies the child, is established practice in pediatric consent processes given the real variation in custody, guardianship, and family circumstances.

Standard 23.2 · *Standard 23: Pediatric Ambulatory Care*

Guidance & Learning

GUIDANCE ASF-AMB-STD23-v3.0

WHY THIS STANDARD EXISTS

The adult accompanying a child to a visit is not always the legal decision-maker, and proceeding on that assumption without verification is a real, specific risk in pediatric care that adult-focused consent processes don't naturally address.

The evidence: [99] Verification of legal decision-making authority, distinct from assumed authority based on who accompanies the child, is established practice in pediatric consent processes given the real variation in custody, guardianship, and family circumstances.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Decision-making authority is specifically verified for each child.	✗ Decision-making authority is assumed from whoever accompanies the child.
✓ A specific, known process exists for non-parent accompanying adults.	✗ No specific process exists for situations involving a non-parent adult.
✓ Age-appropriate communication to the child happens as a genuine, distinct step.	✗ The child is excluded from all communication, treated only as the subject of parental consent.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 Verification happens for new patients but isn't reconfirmed for returning patients whose family circumstances may have changed.
Custody and guardianship arrangements can genuinely change between visits.

2 A protocol exists for non-parent adults but staff aren't consistently confident applying it.
A written protocol needs genuine staff familiarity to function as real protection.

3 Age-appropriate communication happens for older children but not younger ones capable of some understanding.
Even young children can meaningfully participate in age-appropriate communication about their own care.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine decision-maker verification versus assumption.

Week 2 Establish or reinforce a specific protocol for non-parent accompanying adults.

Week 3 Build age-appropriate child communication into the standard visit structure.

Ongoing Reconfirm decision-making authority periodically for returning patients.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff how they'd handle a grandparent or other relative bringing in a child without the parent present.
A specific, confident answer reveals genuine protocol readiness, not improvisation.

Observe whether the child is spoken to directly, not only about, during a visit.
This reveals whether age-appropriate communication is genuine practice, not just a stated principle.

E-LEARNING academy.gmj.ge/amb-std23-2-decision-maker-consent — 30 min · complete before self-assessment

	Standard 23.3 NON-NEGOTIABLE · *Standard 23: Pediatric Ambulatory Care* **Vaccination Records Are Verified Against the Current Schedule, Not Assumed Current**	ASSESSMENT ASF-AMB-STD23-v3.0
CR FULL	TR FULL	SM FULL / ST FULL

23.3
NON-NEGOTIABLE
L1

THE STANDARD

Vaccination Records Are Verified Against the Current Schedule, Not Assumed Current

Vaccination status is actively verified against the current recommended schedule at every visit, with any gap specifically identified and addressed — not assumed up to date because no concern was raised, or because the family reports the child is current.

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

1	**Is vaccination status actively checked against the current recommended schedule at every visit, not only when specifically raised?** *An active, routine check, not dependent on the visit's specific reason or family-initiated request.* Doc: Vaccination verification record	YES	PARTIAL	NO
2	**Is family-reported vaccination status cross-checked against a documented record where one exists, not accepted without verification?** *Genuine cross-checking against documentation, not accepted report alone.* Doc: Documentation cross-check process	YES	PARTIAL	NO
3	**When a gap is identified, is there a specific, defined process for addressing it, not just noting it?** *A real, active response, not passive documentation of a known gap.* Doc: Gap resolution 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 practice review*	Reviews records for active vaccination status verification at routine visits, not only when specifically raised.
DOCUMENT *Cross-check process review*	Reviews whether family-reported status is cross-checked against documented records.
DOCUMENT *Gap resolution review*	Reviews the specific process for addressing an identified vaccination gap.

REFERENCES

[100] Active verification of vaccination status against the current recommended immunization schedule, rather than reliance on unverified parent report, is established practice for identifying and closing immunization gaps in pediatric ambulatory care.

Standard 23.3 · *Standard 23: Pediatric Ambulatory Care*

Guidance & Learning

GUIDANCE ASF-AMB-STD23-v3.0

WHY THIS STANDARD EXISTS

A vaccination gap that goes unnoticed provides no protection at all, and family-reported status, while a useful starting point, is not always accurate — active verification against the actual current schedule is what catches a gap in time to address it.

The evidence: [100] Active verification of vaccination status against the current recommended immunization schedule, rather than reliance on unverified parent report, is established practice for identifying and closing immunization gaps in pediatric ambulatory care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Vaccination status is actively checked at every visit, regardless of visit reason.	✗ Vaccination status is checked only when specifically raised by the family.
✓ Family-reported status is cross-checked against documented records where available.	✗ Family-reported status is accepted without any cross-check.
✓ A specific, active process addresses any identified gap.	✗ An identified gap is noted but not actively addressed.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Verification happens at well-child visits but not consistently at sick visits, even when overdue.**
A sick visit is still a genuine opportunity to catch and address an overdue vaccination gap.

2 **Cross-checking happens when records are readily available but isn't actively pursued when they aren't.**
Actively seeking documentation, rather than only checking what's already at hand, closes more real gaps.

3 **Gaps are identified and discussed but follow-through on actually closing them isn't tracked.**
A discussed gap that isn't tracked to resolution can remain open indefinitely.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current vaccination verification practice across different visit types.

Week 2 Establish active verification at every visit, not only well-child visits.

Week 3 Build a specific gap resolution process with tracking to completion.

Ongoing Audit gap identification and resolution tracking periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask whether vaccination status is checked during a sick visit specifically.
This is where verification most commonly lapses relative to routine well-child visits.

Ask for a real example of an identified gap and how it was actually resolved.
A real example reveals whether gap resolution is genuine practice, not just identification.

E-LEARNING academy.gmj.ge/amb-std23-3-vaccination-verification — 30 min · complete before self-assessment

STANDARD 24

Medical Tourism

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

10 criteria

	Standard 24.1 **NON-NEGOTIABLE** · *Standard 24: Medical Tourism* **Pricing Transparency for International Patients**	**ASSESSMENT** ASF-AMB-STD24-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

24.1
NON-NEGOTIABLE
L1

THE STANDARD

Pricing Transparency for International Patients

International patients receive a complete, written, all-inclusive cost estimate before travel is booked — covering the procedure and commonly needed extras — not a partial quote that grows once the patient has already committed to travelling.

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

1	**Does every international patient receive a complete, written, all-inclusive estimate before booking travel?** *Written and complete, not a verbal figure that leaves room to grow later.* Doc: Written cost estimate documentation	YES	PARTIAL	NO
2	**Does the estimate cover commonly needed extras, not just the base procedure fee?** *Genuinely all-inclusive, not a narrow quote that predictably grows.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific process for handling a genuine, unforeseeable cost change once the patient has arrived?** *A defined, transparent process, not an unexplained addition to the bill.* Doc: Cost change communication 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 *Cost estimate review*	Reviews written estimates provided to a sample of recent international patients for completeness.
ASK *Patient cost experience interview*	Asks a recent international patient whether their final cost matched what they were quoted before travel.
DOCUMENT *Cost change protocol review*	Reviews the process for communicating any genuine, unforeseeable cost change.

REFERENCES

[101] WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force when the patient has limited ability to seek a second opinion or negotiate after arrival.

Standard 24.1 · *Standard 24: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

A patient who has already booked flights and arranged time away from home has far less power to question a cost surprise than a local patient would. All-inclusive, advance pricing isn't a courtesy in this context — it's the only point in the process where a foreign patient can still genuinely walk away.

The evidence: [101] WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force when the patient has limited ability to seek a second opinion or negotiate after arrival.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every international patient receives a complete, written, all-inclusive estimate before booking.	✗ Estimates are verbal, partial, or given only after the patient has already committed to travel.
✓ The estimate genuinely covers commonly needed extras, not just the base fee.	✗ The quote covers only the base procedure, with predictable extras added later.
✓ A transparent, defined process exists for any genuine cost change.	✗ Cost increases appear on the final bill without prior communication.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Estimates are written and complete for the primary procedure but not for commonly bundled extras.**
A patient comparing quotes needs the genuinely full picture, not just the headline procedure cost.

2 **The estimate is provided in writing but only after initial travel arrangements are already underway.**
The protective value of advance pricing depends on it arriving before the patient's negotiating position weakens.

3 **A cost change process exists but isn't proactively explained to patients in advance.**
A process patients don't know about doesn't provide real reassurance if a change occurs.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current pricing communication practice against genuine advance, all-inclusive standard.

Week 2 Build a complete, written estimate template covering commonly needed extras.

Week 3 Establish a transparent process for communicating any genuine cost change.

Ongoing Audit final costs against original estimates for a sample of patients.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a recent international patient directly whether the final cost matched the original quote.
This is the clearest, most direct test of genuine pricing transparency.

Ask to see a written estimate for a specific, real patient, not a generic template.
A real example reveals whether the practice is genuinely followed, not just documented in policy.

E-LEARNING academy.gmj.ge/amb-std24-1-pricing-transparency — 30 min · complete before self-assessment

	Standard 24.2 **NON-NEGOTIABLE** · *Standard 24: Medical Tourism* **Remote Records Transfer to Home-Country Physician**	**ASSESSMENT** ASF-AMB-STD24-v3.0
CR N/A	**TR** FULL	**SM** FULL	**ST** FULL

24.2
NON-NEGOTIABLE
L1

THE STANDARD

Remote Records Transfer to Home-Country Physician

A complete, usable record of the care provided is genuinely transferred to the patient's home-country physician before or immediately after the patient departs — not left to the patient to request, translate, and forward themselves.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a specific, complete record handoff to the patient's home provider actually completed before or immediately after departure?** *A genuine, completed handoff, not records that exist but were never actually transmitted or confirmed received.* Doc: Record handoff completion record	YES	PARTIAL	NO
2	**Are records provided in a form the home provider can actually use — appropriate language, standard format?** *Genuinely usable documentation, not technically provided but practically unusable.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific process for the patient to reach this facility if a complication arises after returning home?** *A specific, known contact pathway, not an assumption the patient would figure out how to reach someone.* Doc: Post-departure contact 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 *Handoff completion review*	Reviews records confirming actual completed handoff, not just record availability.
OBSERVE *Record usability check*	Checks whether handoff records are genuinely usable by a home provider, in appropriate language and format.
DOCUMENT *Post-departure contact review*	Reviews the specific post-departure contact protocol provided to patients.

REFERENCES

[102] Continuity of care across international transitions is identified in cross-border healthcare literature as a distinct risk point, with incomplete or inaccessible record transfer directly linked to preventable post-return complications.

Standard 24.2 · *Standard 24: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

A patient who develops a complication after returning home depends entirely on their home provider having genuine, usable information about what was actually done — and the gap between records existing and records actually, usably reaching the right person is exactly where continuity of care most commonly and dangerously fails in medical tourism.

The evidence: [102] Continuity of care across international transitions is identified in cross-border healthcare literature as a distinct risk point, with incomplete or inaccessible record transfer directly linked to preventable post-return complications.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A complete record handoff is genuinely completed and confirmed before or at departure.	✗ Records exist but handoff completion is never confirmed.
✓ Records are provided in a form the home provider can actually use.	✗ Records are technically available but not in a usable language or format.
✓ A specific post-departure contact pathway is provided to every patient.	✗ No specific contact pathway exists for post-departure complications.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Handoff happens reliably when the home provider is known in advance but not when the patient hasn't identified one.**
Even without a named home provider, the patient still needs usable records and a contact pathway.

2 **Records are provided but not translated into a language the likely home provider would use.**
Technically provided but practically unusable documentation doesn't achieve genuine continuity.

3 **A contact pathway exists but isn't clearly communicated to the patient before they leave.**
A pathway the patient doesn't know about functions the same as no pathway at all.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current handoff practice for genuine completion versus theoretical availability.

Week 2 Establish a process for translating records into a usable language and format.

Week 3 Establish and clearly communicate a specific post-departure contact pathway.

Ongoing Confirm handoff completion for every international patient before departure.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example of a completed handoff, not a description of the general process.
A real example reveals whether handoff genuinely happens, not just theoretically exists as a policy.

Ask a patient directly how they'd reach this facility if a problem developed after they returned home.
A confident, specific answer reveals whether the contact pathway was genuinely communicated.

E-LEARNING academy.gmj.ge/amb-std24-2-records-transfer — 30 min · complete before self-assessment

Standard 24.3 **NON-NEGOTIABLE** · *Standard 24: Medical Tourism*

Language Access for Foreign Patients

ASSESSMENT ASF-AMB-STD24-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

24.3
NON-NEGOTIABLE
L1

THE STANDARD

Language Access for Foreign Patients

Foreign patients have access to a genuinely competent interpreter for consent, treatment discussions, and aftercare instructions — not an ad hoc arrangement using whichever staff member happens to speak some of the patient's language.

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

1	**Is a genuinely competent, trained interpreter used for consent, treatment discussion, and aftercare instructions?** *Trained interpreter competency, not ad hoc bilingual staff pressed into service.* Doc: Interpreter engagement record	YES	PARTIAL	NO
2	**Is interpreter access arranged before the patient arrives, not improvised on the day?** *Planned in advance, matched to the patient's actual language.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Can the patient explain back key consent and aftercare information in their own words?** *Tests genuine understanding, not just that interpretation technically 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 *Interpreter engagement review*	Reviews records for genuine, trained interpreter engagement, not ad hoc bilingual staff use.
ASK *Advance arrangement interview*	Asks staff how interpreter access is arranged before an international patient's arrival.
OBSERVE *Patient understanding check*	Checks whether the patient can explain back key consent and aftercare information.

REFERENCES

[103] Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

Standard 24.3 · *Standard 24: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

Language access for medical tourism carries the same stakes as language access anywhere else in care, with one added complication: the patient has no established relationship with the local health system to fall back on if communication fails. Genuine interpreter competency, not improvised bilingual staff, is what this actually requires.

The evidence: [103] Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuinely trained, competent interpreter is used consistently.	✗ Whichever staff member happens to speak some of the language is used ad hoc.
✓ Interpreter access is arranged in advance, matched to the patient's language.	✗ Interpreter arrangements are improvised on the day of the visit.
✓ Patients can explain back key information in their own words.	✗ Patients cannot explain back consent or aftercare information.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A trained interpreter is used for the main consultation but not for aftercare instructions at discharge.**
Aftercare instructions carry real, ongoing risk if misunderstood after the patient has left.

2 **Interpreter access exists but isn't confirmed until the patient has already arrived.**
Advance confirmation avoids a scramble that risks falling back on ad hoc arrangements.

3 **Interpretation occurs but understanding is never actively checked afterward.**
Interpretation without verified understanding doesn't confirm the communication actually worked.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current interpreter arrangements for international patients.

Week 2 Establish advance booking of trained interpreters matched to expected patient languages.

Week 3 Extend interpreter use explicitly to aftercare instruction, not only initial consultation.

Ongoing Spot-check patient understanding after interpreted consultations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask specifically about aftercare instruction interpretation, not just the main consultation.
This is where interpreter use most commonly lapses.

Ask a patient to explain back their own aftercare instructions.
This tests genuine understanding, not just that an interpreter was present.

E-LEARNING academy.gmj.ge/amb-std24-3-language-access — 30 min · complete before self-assessment

Standard 24.4 **CORE** · *Standard 24: Medical Tourism*

Travel, Accommodation, and Logistics Coordination

ASSESSMENT ASF-AMB-STD24-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

24.4
CORE
L1

THE STANDARD

Travel, Accommodation, and Logistics Coordination

The facility provides or coordinates genuine support for travel and accommodation logistics around the procedure — not leaving an international patient, often recovering from treatment, to navigate this entirely alone in an unfamiliar country.

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

1	**Does the facility provide or genuinely coordinate travel and accommodation support, not just a list of options?** *Real coordination, not information the patient must act on entirely alone.* Doc: Logistics coordination documentation	YES	PARTIAL	NO
2	**Is accommodation genuinely suitable for post-procedure recovery, not just conveniently located?** *Suitability for actual recovery needs, not proximity alone.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific point of contact for logistics problems during the patient's stay?** *A specific, known contact, not an assumption the patient will manage independently.* Doc: Logistics contact protocol	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 *Coordination support review*	Reviews what genuine travel and accommodation coordination is provided, not just informational lists.
ASK *Accommodation suitability interview*	Asks whether recommended or arranged accommodation genuinely suits post-procedure recovery needs.
DOCUMENT *Logistics contact review*	Reviews the specific point of contact provided for logistics issues during the stay.

REFERENCES

[104] Patient-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction and perceived safety.

Standard 24.4 · *Standard 24: Medical Tourism*

Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

A patient recovering from a procedure in an unfamiliar country, without local language fluency or a support network, faces real logistical risk beyond the clinical care itself. Genuine coordination support — not just a list of nearby hotels — reduces stress that can itself affect recovery.

The evidence: [104] Patient-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction and perceived safety.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Genuine coordination support is provided, not just an information list.	✗ Patients receive only a generic list of nearby hotels with no real coordination.
✓ Accommodation is suitable for actual recovery needs.	✗ Accommodation suitability for recovery is never considered.
✓ A specific logistics contact is available during the patient's stay.	✗ No specific contact exists for logistics problems during the stay.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Coordination support is offered for the arrival but not for the return journey.**
Logistics risk doesn't end once the procedure itself is complete.

2 **Accommodation recommendations exist but aren't verified for genuine recovery suitability.**
A recommendation that hasn't been checked may not actually suit a recovering patient's needs.

3 **A contact exists but isn't clearly communicated or reachable outside office hours.**
Logistics problems can arise at any time, not only during business hours.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current logistics support against genuine coordination versus informational lists.

Week 2 Verify recommended accommodation options for genuine recovery suitability.

Week 3 Establish a specific, reachable logistics contact for the duration of the stay.

Ongoing Gather patient feedback on logistics coordination quality.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a recent international patient how logistics support actually worked in practice.
Real experience reveals more than a description of intended coordination.

Ask what happens if a logistics problem arises outside office hours.
This reveals whether support is genuinely continuous, not just during standard hours.

E-LEARNING academy.gmj.ge/amb-std24-4-logistics-coordination — 30 min · complete before self-assessment

Standard 24.5 **NON-NEGOTIABLE** · *Standard 24: Medical Tourism*

Post-Return Complication Tracking

ASSESSMENT ASF-AMB-STD24-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

24.5
NON-NEGOTIABLE
L1

THE STANDARD

Post-Return Complication Tracking

The facility actively tracks what happens to international patients after they return home — including complications discovered by a home-country physician — not just relying on a generic follow-up call that a satisfied patient may not bother answering.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific, active process for tracking international patient outcomes after they return home, not just a generic courtesy call?** *An active, structured process, not a single, easily-missed follow-up attempt.* Doc: Post-return tracking protocol	YES	PARTIAL	NO
2	**Is there a specific pathway for a home-country physician to report a complication back to this facility?** *A real, known pathway, not an assumption the physician would somehow know how to reach the facility.* Doc: Physician reporting pathway	YES	PARTIAL	NO
3	**Are tracked complications reviewed and used to inform practice, not just recorded?** *Genuine learning from real outcomes, not passive record-keeping.* 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 *Tracking protocol review*	Reviews the specific, active process for tracking international patient outcomes after return.
DOCUMENT *Physician reporting pathway review*	Reviews the specific pathway for a home-country physician to report a complication.
ASK *Outcome review interview*	Asks staff for a real example of a tracked complication that informed a practice change.

REFERENCES

[105] Post-operative complication tracking following international medical travel is identified in the medical tourism literature as a systemic gap, with most facilities lacking any mechanism to learn about complications that surface after the patient has returned home.

Standard 24.5 · *Standard 24: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

This is one of the biggest gaps in medical tourism practice generally: accountability effectively ends the moment the patient boards their flight home. A complication discovered weeks later by a home physician almost never makes it back to the facility that performed the original procedure, which means the facility never learns from outcomes it should be learning from.

The evidence: [105] Post-operative complication tracking following international medical travel is identified in the medical tourism literature as a systemic gap, with most facilities lacking any mechanism to learn about complications that surface after the patient has returned home.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ An active, structured process tracks international patient outcomes after return.	✗ Tracking relies on a single generic follow-up call with no structured process.
✓ A specific, known pathway exists for home-country physicians to report complications.	✗ No pathway exists for a home-country physician to report a complication.
✓ Tracked complications are genuinely reviewed and inform practice.	✗ Complications, if tracked, are recorded but never reviewed for learning.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Follow-up happens once but isn't repeated if the patient doesn't respond the first time.**
A single missed attempt shouldn't end the tracking process for a real complication risk.

2 **A reporting pathway exists but isn't communicated to the patient or their home provider.**
An unknown pathway provides no real function.

3 **Complications are recorded but never reviewed collectively for patterns.**
Individual records without pattern review miss the systemic learning this tracking is meant to provide.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current post-return follow-up practice for structure versus a single generic attempt.

Week 2 Establish a specific pathway for home-country physicians to report complications.

Week 3 Build a process for reviewing tracked outcomes and feeding findings into practice.

Ongoing Track complication rates and review for patterns periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real example of a complication learned about after a patient returned home.
A real example, or its honest absence, reveals whether tracking genuinely functions.

Ask how a home-country physician would actually reach this facility to report a concern.
A specific, confident answer reveals a genuine pathway, not an assumed one.

E-LEARNING academy.gmj.ge/amb-std24-5-complication-tracking — 30 min · complete before self-assessment

Standard 24.6 **CORE** · *Standard 24: Medical Tourism*

Visa and Embassy Support Documentation

ASSESSMENT ASF-AMB-STD24-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

24.6
CORE
L1

THE STANDARD

Visa and Embassy Support Documentation

The facility provides the specific documentation international patients need for medical visa applications and embassy requirements, correctly and promptly — not generic paperwork that leaves the patient to figure out what is actually required themselves.

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

1	**Does the facility provide the specific documentation needed for medical visa applications, correctly and promptly?** *Specific, correct documentation matched to actual requirements, not generic paperwork.* Doc: Visa documentation record	YES	PARTIAL	NO
2	**Is documentation provided with enough lead time for realistic visa processing?** *Genuine lead time, not documentation issued so late that delay becomes likely.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific process for correcting a documentation error quickly if one is identified?** *A specific, responsive process, not a slow, informal correction path.* Doc: Documentation correction protocol	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 *Documentation accuracy review*	Reviews visa and embassy documentation provided to a sample of international patients for correctness.
ASK *Lead time interview*	Asks staff how far in advance documentation is typically provided relative to expected processing time.
DOCUMENT *Correction process review*	Reviews the process for quickly correcting a documentation error if identified.

REFERENCES

[106] Medical travel facilitation literature identifies documentation delays and errors as a leading cause of care-seeking delay for international patients, with downstream clinical consequences for time-sensitive conditions.

Standard 24.6 · *Standard 24: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

Visa and immigration requirements for medical travel are specific and vary by country, and a delayed or incorrect document can derail a patient's ability to travel for care at all, sometimes with real clinical urgency behind the delay. This is a logistics function, but one with real clinical consequences when it fails.

The evidence: [106] Medical travel facilitation literature identifies documentation delays and errors as a leading cause of care-seeking delay for international patients, with downstream clinical consequences for time-sensitive conditions.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Documentation is specific, correct, and matched to actual visa requirements.	✗ Documentation is generic, leaving the patient to determine actual requirements.
✓ Documentation is provided with realistic lead time for processing.	✗ Documentation arrives too close to travel dates for realistic processing.
✓ A specific, responsive correction process exists for errors.	✗ Errors, when identified, take a long time to correct.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Documentation is generally correct but not verified against the specific requirements of every relevant country.**
Requirements genuinely vary by country, and a generic approach risks missing country-specific needs.

2 **Lead time is adequate for common cases but not for countries with longer processing times.**
Processing time varies significantly by country, and lead time should reflect the patient's actual situation.

3 **A correction process exists but isn't clearly known to staff handling these requests.**
An unfamiliar process functions poorly under real time pressure.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current visa documentation practice for accuracy and lead time.

Week 2 Establish country-specific documentation checklists for common patient origins.

Week 3 Establish a specific, responsive correction process for documentation errors.

Ongoing Track visa-related delays and adjust lead time practice accordingly.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real example of documentation provided for a specific country's requirements.
A real, specific example reveals genuine accuracy, not a generic template.

Ask what happens when a documentation error is discovered close to a travel date.
This reveals whether the correction process is genuinely responsive under real pressure.

E-LEARNING academy.gmj.ge/amb-std24-6-visa-documentation — 30 min · complete before self-assessment

	Standard 24.7 NON-NEGOTIABLE · *Standard 24: Medical Tourism* **International Patient Complaint and Redress Process**	ASSESSMENT ASF-AMB-STD24-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

24.7
NON-NEGOTIABLE
L1

THE STANDARD

International Patient Complaint and Redress Process

International patients have access to a genuine complaint and redress process reachable from their home country, with real evidence complaints are addressed — not a process that functionally only works for a patient still physically present in the country.

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

1	**Is there a specific complaint channel genuinely reachable from the patient's home country, not requiring physical presence?** *Genuine remote accessibility, not a channel that functionally only works locally.* Doc: Complaint channel documentation	YES	PARTIAL	NO
2	**Is the complaint channel accessible in relevant languages, not only the local language?** *Genuine language accessibility, not a barrier that excludes exactly the patients most likely to need it.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there real, documented evidence that complaints from returned patients are actually addressed?** *Genuine follow-through, not a channel that exists but produces no real response.* Doc: Complaint 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

DOCUMENT *Complaint channel accessibility review*	Reviews whether the complaint channel is genuinely reachable and usable from abroad.
DOCUMENT *Language accessibility review*	Reviews whether the complaint channel is accessible in relevant patient languages.
DOCUMENT *Resolution record review*	Reviews documented evidence that complaints from returned patients are genuinely addressed.

REFERENCES

[107] Cross-border patient redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international patients face after returning home.

Standard 24.7 · *Standard 24: Medical Tourism*

Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

A complaint channel that requires being physically present, or fluent in the local language, or navigating an unfamiliar system from abroad effectively excludes exactly the patients most likely to need it — those who have already returned home when a real problem becomes apparent.

The evidence: [107] Cross-border patient redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international patients face after returning home.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The complaint channel is genuinely reachable and usable from the patient's home country.	✗ The complaint process functionally requires physical presence or local language fluency.
✓ The channel is accessible in relevant languages, not only the local one.	✗ No accommodation exists for patients who don't speak the local language.
✓ Real, documented evidence shows complaints are genuinely addressed.	✗ No documented evidence exists that complaints from returned patients are addressed.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A remote complaint channel exists but response times are significantly slower than for local complaints.**
A technically accessible channel that responds too slowly doesn't provide genuine redress.

2 **The channel is accessible by email but not genuinely responsive to patients writing in other languages.**
Technical accessibility without genuine language responsiveness doesn't achieve real access.

3 **Complaints are received but resolution isn't consistently documented or communicated back to the patient.**
An undocumented or uncommunicated resolution provides little real reassurance to the patient.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current complaint channel for genuine remote and language accessibility.

Week 2 Establish or strengthen remote-accessible complaint intake in relevant languages.

Week 3 Establish documented resolution tracking with communication back to the patient.

Ongoing Track response times and resolution rates for international patient complaints specifically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real example of a complaint received from a patient after they had already returned home.
A real example reveals whether the channel genuinely functions for exactly the patients who need it most.

Test the complaint channel's accessibility in a language other than the local one.
This directly reveals genuine language accessibility, not an assumption of it.

E-LEARNING academy.gmj.ge/amb-std24-7-complaint-redress — 30 min · complete before self-assessment

	Standard 24.8 **NON-NEGOTIABLE** · *Standard 24: Medical Tourism* **Facilitators and Agents Are Verified, Not Assumed Legitimate**	**ASSESSMENT** ASF-AMB-STD24-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

24.8
NON-NEGOTIABLE
L1

THE STANDARD

Facilitators and Agents Are Verified, Not Assumed Legitimate

Any medical tourism facilitator or agent referring patients to this facility is specifically verified — real business registration, a real, checkable track record — with the verification documented, not accepted based on the volume of patients they refer or how professional their marketing appears.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is each facilitator or agent specifically verified for legitimate business registration and a checkable track record?** *Genuine, specific verification, not accepted based on referral volume or marketing professionalism alone.* Doc: Facilitator verification record	YES	PARTIAL	NO
2	**Is verification documented and periodically reconfirmed, not done once and assumed to remain valid indefinitely?** *An active, periodically reconfirmed process, not a one-time check.* Doc: Periodic reconfirmation record	YES	PARTIAL	NO
3	**Is there a specific process for reviewing what a facilitator actually tells patients about this facility?** *Active oversight of facilitator representations, not an assumption they accurately represent the facility.* Doc: Facilitator representation review process	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 *Facilitator verification review*	Reviews verification records for business registration and track record for each facilitator.
DOCUMENT *Reconfirmation schedule review*	Reviews whether verification is periodically reconfirmed, not a one-time check.
ASK *Representation review interview*	Asks staff how they review what facilitators actually tell patients about the facility.

REFERENCES

[108] Medical tourism governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the treating facility itself.

Standard 24.8 · *Standard 24: Medical Tourism*

Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

Medical tourism facilitators sit between the patient and the facility with real influence over what the patient is told and expects, and an unverified facilitator can misrepresent risks, costs, or outcomes in ways the facility only discovers after a patient arrives already misinformed.

The evidence: [108] Medical tourism governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the treating facility itself.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Each facilitator is specifically verified for legitimate registration and track record.	✗ Facilitators are accepted based on referral volume without specific verification.
✓ Verification is documented and periodically reconfirmed.	✗ Verification, if it happened, was never reconfirmed after initial acceptance.
✓ A specific process reviews what facilitators actually represent to patients.	✗ No process exists to review what facilitators actually tell patients.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Verification happens for new facilitator relationships but isn't reconfirmed for long-standing ones.**
A facilitator's legitimacy and practices can change over time even after an initial, valid verification.

2 **Verification covers business registration but not the accuracy of their patient-facing representations.**
A legitimately registered facilitator can still misrepresent risks or outcomes to patients.

3 **Patients occasionally arrive with expectations that don't match what the facility actually offers.**
This is a real, observable signal that facilitator representation review deserves closer attention.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current facilitator relationships for specific verification versus assumed legitimacy.

Week 2 Establish or strengthen documented verification for every facilitator relationship.

Week 3 Build a periodic reconfirmation schedule and a process for reviewing facilitator representations.

Ongoing Review patient expectations against facility reality as an indicator of facilitator accuracy.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual verification record for a specific, named facilitator.
A specific, documented record is the real evidence of genuine verification, not assumed legitimacy.

Ask a recent international patient what they were told by their facilitator before arrival.
This reveals whether facilitator representations actually match facility reality.

E-LEARNING academy.gmj.ge/amb-std24-8-facilitator-verification — 30 min · complete before self-assessment

	Standard 24.9 **NON-NEGOTIABLE** · *Standard 24: Medical Tourism* **Travel-Associated Infection Risk Protocol**	**ASSESSMENT** ASF-AMB-STD24-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

24.9
NON-NEGOTIABLE
L1

THE STANDARD

Travel-Associated Infection Risk Protocol

International patients are assessed for travel-associated infection risk specific to their journey and country of origin, with appropriate screening and precautions applied — not treated identically to a local patient with no recent travel history.

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

1	**Are international patients specifically assessed for travel-associated infection risk, not treated identically to local patients?** *A specific, distinct assessment step, not folded into or skipped within general intake.* Doc: Travel-associated infection risk assessment	YES	PARTIAL	NO
2	**Does the assessment account for the patient's specific country of origin and recent travel history?** *Specific to this patient's actual journey, not a generic travel question.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are appropriate precautions applied based on the assessment, not just documented without changing practice?** *Genuine, applied precautions, not an assessment that doesn't change anything.* Doc: Precaution application 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 *Risk assessment review*	Reviews records for a specific, distinct travel-associated infection risk assessment.
DOCUMENT *Assessment specificity review*	Reviews whether assessment content reflects the patient's specific country of origin and travel history.
OBSERVE *Precaution application check*	Checks whether precautions indicated by the assessment are genuinely applied in practice.

REFERENCES

[109] Travel-associated antimicrobial resistance and infection risk is a documented, distinct category in infection prevention literature, with international medical travel specifically identified as a transmission risk pathway requiring targeted screening protocols.

Standard 24.9 · *Standard 24: Medical Tourism*

Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

International patients carry different exposure histories, and in some cases different antimicrobial resistance profiles, than the local population. A generic infection control approach that doesn't account for this misses a real, specific, and well-documented risk category unique to cross-border care.

The evidence: [109] Travel-associated antimicrobial resistance and infection risk is a documented, distinct category in infection prevention literature, with international medical travel specifically identified as a transmission risk pathway requiring targeted screening protocols.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ International patients undergo a specific, distinct travel-associated infection risk assessment.	✗ International patients are assessed identically to local patients with no travel-specific step.
✓ The assessment reflects the patient's specific country of origin and travel history.	✗ The assessment is generic, not reflecting the patient's actual journey.
✓ Appropriate precautions are genuinely applied based on the assessment.	✗ Precautions are documented but not genuinely applied in practice.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The assessment happens for surgical procedures but not consistently for other invasive procedures.**
Travel-associated infection risk applies to any procedure carrying genuine infection exposure, not surgery alone.

2 **Country of origin is recorded but not specifically used to inform the risk assessment.**
Recorded information that doesn't inform the actual assessment provides no real protective value.

3 **Precautions are identified but application is inconsistent across different staff.**
Consistent application across everyone involved is what gives the precautions real protective value.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current intake practice for a specific travel-associated infection risk step.

Week 2 Build a structured assessment reflecting country of origin and travel history.

Week 3 Establish consistent application of indicated precautions across all staff.

Ongoing Audit assessment completion and precaution application for international patients.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the specific travel-associated risk assessment for a recent international patient.
A specific, real example reveals whether this is genuine practice, not just a policy statement.

Ask staff how the assessment differs for patients from different countries of origin.
A specific, informed answer reveals genuine understanding, not a generic infection-control response.

E-LEARNING academy.gmj.ge/amb-std24-9-travel-infection-risk — 30 min · complete before self-assessment

	Standard 24.10 NON-NEGOTIABLE · *Standard 24: Medical Tourism* **Post-Procedure Travel Timing and Venous Thromboembolism Risk**	ASSESSMENT ASF-AMB-STD24-v3.0
CR N/A	TR FULL	SM FULL / ST FULL

24.10
NON-NEGOTIABLE
L1

THE STANDARD

Post-Procedure Travel Timing and Venous Thromboembolism Risk

Every international patient receives a specific, documented discussion of safe travel timing after their procedure — including the elevated blood clot risk from combining recent surgery with air travel — not a general assumption that the patient will figure out when it is safe to fly.

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

1	**Does every international patient receive a specific, documented discussion of safe travel timing for their specific procedure?** *A specific, procedure-appropriate discussion, not a generic travel disclaimer.* Doc: Travel timing discussion documentation	YES	PARTIAL	NO
2	**Is the discussion specific to blood clot risk from combining this procedure with air travel, not general recovery advice?** *The specific risk named directly, not folded into general aftercare instructions.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Can the patient explain back the recommended minimum time before flying, specific to their own procedure?** *Tests genuine understanding specific to this patient, not general awareness that travel timing matters.* 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 *Travel timing documentation review*	Reviews records for a specific, procedure-appropriate travel timing discussion.
OBSERVE *Discussion specificity observation*	Observes whether the discussion specifically names blood clot risk, not general recovery advice alone.
ASK *Patient understanding check*	Asks a patient to explain back the recommended travel timing specific to their procedure.

REFERENCES

[110] Established international travel health guidance recommends against air travel for 10-14 days following major surgery given the combined risk of surgery and air travel for blood clots, including deep vein thrombosis and pulmonary embolism.

Standard 24.10 · *Standard 24: Medical Tourism*
Guidance & Learning

GUIDANCE ASF-AMB-STD24-v3.0

WHY THIS STANDARD EXISTS

Air travel and surgery each independently increase blood clot risk, and combining them within an unsafe window is a genuine, documented danger specific to medical tourism — a patient who travelled specifically for this procedure has an obvious incentive to fly home as soon as they feel able, which is exactly why this needs to be an explicit conversation, not an assumption.

The evidence: [110] Established international travel health guidance recommends against air travel for 10-14 days following major surgery given the combined risk of surgery and air travel for blood clots, including deep vein thrombosis and pulmonary embolism.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every international patient receives a specific, documented travel timing discussion.	✗ Travel timing is left to general recovery instructions without specific discussion.
✓ The discussion specifically names blood clot risk, not general recovery advice alone.	✗ Blood clot risk isn't specifically named or explained.
✓ Patients can explain back the specific recommended timing for their own procedure.	✗ Patients cannot describe any specific recommended timing.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The discussion happens for major procedures but is abbreviated for shorter or perceived lower-risk ones.**
Even shorter procedures combined with long-haul travel carry genuine, documented risk.

2 **Timing is mentioned but the specific reasoning behind it isn't explained.**
Understanding why matters for a patient weighing their own travel decision against the recommendation.

3 **The discussion happens but isn't documented, relying on staff memory that it occurred.**
Undocumented discussion is difficult to distinguish from a discussion that didn't happen.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for specific, documented travel timing discussion.

Week 2 Build a specific, procedure-appropriate travel timing script into pre-departure counselling.

Week 3 Establish documentation confirming the discussion occurred for every international patient.

Ongoing Spot-check patient understanding of their specific recommended timing.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask an international patient directly what they were told about travel timing.
This tests actual understanding, not just that a conversation is assumed to have occurred.

Check documentation for a shorter, perceived lower-risk procedure specifically.
This is where the discussion most commonly gets abbreviated or skipped.

E-LEARNING academy.gmj.ge/amb-std24-10-travel-timing — 30 min · complete before self-assessment

STANDARD 25

Refugee & Migrant Health

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

10 criteria

	Standard 25.1 NON-NEGOTIABLE · *Standard 25: Refugee & Migrant Health* **Language and Communication Aids — Interpreters and Cultural Mediators**	ASSESSMENT ASF-AMB-STD25-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

25.1
NON-NEGOTIABLE
L1

THE STANDARD

Language and Communication Aids — Interpreters and Cultural Mediators

Trained interpreters or cultural mediators are engaged for language-discordant consultations — never minor children, and only family members when genuinely no other option exists and the situation is not high-risk.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are trained interpreters or cultural mediators engaged for language-discordant consultations?** *Not ad hoc bilingual staff or family members as the default.* Doc: Interpreter engagement record	YES	PARTIAL	NO
2	**Is a minor ever used to facilitate interpretation for a family member?** *This should never happen — a specific, absolute rule, not a judgement call.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When a family member interprets due to genuine unavailability of a trained interpreter, is this reserved for low-risk situations only?** *Not used for informed consent, complex care, or bad news — situations WHO specifically flags as requiring professional language support.* 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 *Interpreter engagement review*	Reviews records for evidence of trained interpreter or cultural mediator engagement in language-discordant consultations.
ASK *Minor-interpreter policy check*	Asks staff directly whether minors are ever used to interpret, and confirms understanding that this is never acceptable.
OBSERVE *High-risk situation check*	Checks whether family-member interpretation, where it occurs, is confined to genuinely low-risk situations, never consent or bad news.

REFERENCES

[111] World Health Organization. Refugee and Migrant Health: Global Competency Standards for Health Workers. Geneva: WHO; 2021 — Competency Standard 3 states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

Standard 25.1 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

Family members interpreting, especially minors, carries real, well-documented risks — inaccurate interpretation, withheld or distorted information, compromised confidentiality, and trauma to the family member themselves. This is one of the clearest, most specific safeguards in the entire WHO framework, and it exists because the alternative genuinely and measurably harms patients.

The evidence: [111] World Health Organization. Refugee and Migrant Health: Global Competency Standards for Health Workers. Geneva: WHO; 2021 — Competency Standard 3 states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Trained interpreters or cultural mediators are the default for language-discordant consultations. ✓ Staff confirm, without hesitation, that minors are never used to interpret. ✓ Family-member interpretation, when it happens, is reserved for genuinely low-risk situations only.	✗ Ad hoc bilingual staff or family members are the default, with trained interpreters rarely engaged. ✗ A minor has been used to interpret, even occasionally. ✗ Family members interpret for high-risk situations like informed consent or bad news.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Trained interpreters are used for major appointments but family members fill in for quick or informal interactions.**
Risk doesn't scale down proportionally with how brief or informal an interaction feels.

2 **The no-minors rule is understood by senior staff but not consistently reinforced with newer or part-time staff.**
A critical safeguard needs to be embedded in onboarding, not assumed as common knowledge.

3 **Interpreter access exists during clinic hours but reverts to family members for same-day or urgent visits.**
Coverage gaps at specific times undermine an otherwise sound policy.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent language-discordant consultations for interpreter engagement patterns.

Week 2 Establish or reinforce trained interpreter access, including for same-day and urgent visits.

Week 3 Brief all staff explicitly and unambiguously that minors are never used to interpret.

Ongoing Audit family-member interpretation instances to confirm they're confined to genuinely low-risk situations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the minor-interpreter question directly and expect an immediate, confident answer.
Any hesitation on this specific point is a serious signal worth investigating further.

Check interpreter coverage specifically for same-day or urgent appointments.
This is where the policy is most likely to quietly lapse.

E-LEARNING academy.gmj.ge/amb-std25-1-professional-interpretation — 30 min · complete before self-assessment

	Standard 25.2 **NON-NEGOTIABLE** · *Standard 25: Refugee & Migrant Health* **People-Centred Care Adapted to Migration and Displacement Experience**	**ASSESSMENT** ASF-AMB-STD25-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

25.2
NON-NEGOTIABLE
L1

THE STANDARD

People-Centred Care Adapted to Migration and Displacement Experience

Care is genuinely adapted to a patient's migration and displacement experience — including trauma-informed practice, awareness of legal-status barriers to access, and support for continuity of care — not delivered identically regardless of that history.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is care genuinely adapted to a patient's migration and displacement experience, not delivered identically regardless of history?** *Genuine adaptation, not a generic cultural-awareness statement.* Doc: Training record on migration-adapted care	YES	PARTIAL	NO
2	**Is trauma-informed practice genuinely applied, not just referenced as a principle?** *Actual practice adaptation, not an assumption of general sensitivity.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are staff aware of legal-status barriers to access that may affect this specific patient?** *Specific awareness, not a general sense that barriers can exist.* 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	
ASK *Migration-adapted care interview*	Asks staff how they adapt practice specifically for a patient's migration and displacement history.
OBSERVE *Trauma-informed practice observation*	Observes a consultation for genuine trauma-informed practice, not generic sensitivity.
DOCUMENT *Training content review*	Reviews training materials for specific coverage of migration-adapted, trauma-informed care.

REFERENCES

[112] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

Standard 25.2 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

A refugee or migrant patient's health needs and vulnerabilities are shaped by what happened before they ever reached this facility — in their country of origin, in transit, and on arrival. Care that ignores this context, treating every patient as though their history began at the clinic door, misses real, clinically relevant information and can retraumatise someone who has already experienced significant hardship.

The evidence: [112] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Care is genuinely, visibly adapted to migration and displacement history.	✗ Care is delivered identically regardless of migration history.
✓ Trauma-informed practice is actually applied, not just referenced.	✗ Trauma-informed practice exists only as a stated principle, not applied practice.
✓ Staff demonstrate specific awareness of legal-status access barriers.	✗ Staff show no specific awareness of legal-status barriers.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Adaptation happens for patients who disclose their history but isn't proactively considered otherwise.**
Not every patient will volunteer this history unprompted, even when it is clinically relevant.

2 **Staff are aware of the principle but haven't received specific training on applying it.**
General awareness doesn't reliably translate into genuine practice adaptation without specific training.

3 **Continuity of care support exists for patients with stable documentation but not those without it.**
Documentation instability is itself a common feature of this population's situation, not an exception to plan around.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine adaptation to migration and displacement history.

Week 2 Train staff specifically on trauma-informed, migration-adapted practice.

Week 3 Build awareness of legal-status access barriers into standard practice.

Ongoing Review practice adaptation periodically using real case examples.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to describe a specific example of adapting care for a patient's migration history.
A real, specific example reveals genuine practice, not familiarity with the principle.

Ask about continuity of care support specifically for patients without stable documentation.
This is where genuine adaptation is most tested.

E-LEARNING academy.gmj.ge/amb-std25-2-migration-adapted-care — 30 min · complete before self-assessment

	Standard 25.3 **NON-NEGOTIABLE** · *Standard 25: Refugee & Migrant Health* **Supporting Patient Agency Through Genuine Understanding of Care and the Health System**	**ASSESSMENT** ASF-AMB-STD25-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

25.3
NON-NEGOTIABLE
L1

THE STANDARD

Supporting Patient Agency Through Genuine Understanding of Care and the Health System

Patients are supported to genuinely understand both their own care and how to navigate the health system itself — with understanding actively verified through methods like teach-back, in plain language, not assumed from silence, a nod, or general goodwill information about the system.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is understanding actively checked using a teach-back approach, for both the care plan and how to navigate the clinic, not assumed from a nod?** *Asking the patient to explain both back in their own words, not just asking "do you understand?"* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is concrete, practical guidance provided on navigating this clinic specifically — how to book again, what to do for urgent concerns?** *Real navigation guidance, not just general encouragement to seek care.* Doc: Navigation guidance material	YES	PARTIAL	NO
3	**Is information communicated in plain language, avoiding medical jargon, particularly when working through an interpreter?** *Complex terminology strains interpretation and comprehension together.* 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 *Teach-back practice observation*	Observes a consultation, or a simulated scenario, to check whether teach-back genuinely verifies understanding of both care and navigation.
DOCUMENT *Navigation material review*	Reviews any materials or guidance provided on navigating this clinic, in relevant languages.
ASK *Patient understanding check*	Asks a recent refugee or migrant patient to explain back their care plan and how they would book again.

REFERENCES

[113] WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

Standard 25.3 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

For a refugee or migrant patient, understanding an unfamiliar health system can matter as much for long-term health as any single treatment decision, and a patient who nods along without genuinely understanding — particularly through the added layer of interpretation — can leave with a dangerously incomplete picture of both their care and how to access it again.

The evidence: [113] WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Teach-back genuinely verifies understanding of both the care plan and clinic navigation.	✗ Understanding is assumed from a nod or silence, with no active verification.
✓ Concrete, translated navigation guidance is provided, not just general encouragement.	✗ Patients leave understanding their specific treatment but not how to book again.
✓ Plain language is used consistently, especially when working through an interpreter.	✗ Medical jargon is used routinely, straining both interpretation and comprehension.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Teach-back is used for major treatment decisions but not extended to booking or navigation information.**
Understanding how to actually use the clinic matters as much as understanding the immediate care plan.

2 **Navigation support is given verbally but not reinforced with anything the patient can review later.**
Complex information delivered once, verbally, under stress is easily forgotten.

3 **Staff assume system literacy for patients who have visited before, missing gaps that may still exist.**
Prior visits don't reliably correlate with genuine system understanding.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current practice for both understanding-verification and navigation support.

Week 2 Train staff on teach-back technique and develop translated navigation guidance.

Week 3 Brief staff to proactively cover navigation alongside the immediate clinical matter.

Ongoing Spot-check patient understanding of both care and navigation periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual consultation if possible, watching specifically for teach-back covering both care and navigation.
This is a practice that is easy to describe in policy and easy to skip under time pressure.

Ask a patient directly what they understand about booking again or reaching the clinic urgently.
This tests actual system literacy, not just satisfaction with the immediate visit.

E-LEARNING academy.gmj.ge/amb-std25-3-understanding-and-navigation — 30 min · complete before self-assessment

Standard 25.4 **CORE** · *Standard 25: Refugee & Migrant Health*

Collaborative Practice Across Health and Social Services

ASSESSMENT ASF-AMB-STD25-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

25.4
CORE
L1

THE STANDARD

Collaborative Practice Across Health and Social Services

The facility actively engages with legal, education, employment, housing, and other social support services relevant to refugee and migrant patients, and conducts effective handover of care that includes migration- and displacement-related context — not treating health care as isolated from these interconnected factors.

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

1	**Does the facility actively engage with relevant social support services, not treat health care in isolation?** *Genuine, active engagement, not a general awareness that such services exist.* Doc: Social services engagement record	YES	PARTIAL	NO
2	**Does handover to another provider specifically include migration- and displacement-related context?** *Specific inclusion of this context, not a generic clinical handover.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are staff aware of specific local services relevant to this population, not just services generally?** *Specific, current knowledge, not a vague sense that support services exist somewhere.* 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 *Social services engagement review*	Reviews evidence of active engagement with relevant social support services.
DOCUMENT *Handover content review*	Reviews handover documentation for specific inclusion of migration-related context.
ASK *Local services knowledge interview*	Asks staff to name specific local services relevant to refugee and migrant patients.

REFERENCES

[114] WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

Standard 25.4 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

Housing, legal status, and social support don't just sit alongside a refugee or migrant patient's health — they actively shape it. A facility that treats health in isolation from these factors, or that fails to hand over migration-related context to the next provider in a patient's care, misses information a purely clinical view wouldn't capture.

The evidence: [114] WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The facility actively, genuinely engages with relevant social support services.	✗ Health care is treated in isolation from social support factors.
✓ Handover to other providers specifically includes migration-related context.	✗ Handover is generic, omitting migration-related context.
✓ Staff can name specific, current local services relevant to this population.	✗ Staff have no specific knowledge of relevant local services.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Engagement happens with legal services but not consistently with housing or employment support.**
Each of these factors can independently and significantly affect a patient's health.

2 **Handover includes clinical information but omits migration-related context that shaped the care given.**
The next provider benefits from the same contextual understanding this facility relied on.

3 **Staff know general categories of support exist but not specific, current local contacts.**
Specific, current knowledge is what makes a referral actually actionable for the patient.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Map current engagement with relevant social support services.

Week 2 Establish or strengthen specific, current local service contacts.

Week 3 Build migration-related context into standard handover documentation.

Ongoing Refresh knowledge of local services periodically as availability changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name a specific local service they would refer a patient to, not a general category.
Specificity reveals genuine, current knowledge rather than assumed awareness.

Review a real handover document for migration-related context inclusion.
A real example reveals whether this happens in practice, not just in policy.

E-LEARNING academy.gmj.ge/amb-std25-4-collaborative-practice — 30 min · complete before self-assessment

	Standard 25.5 **CORE** · *Standard 25: Refugee & Migrant Health* **Evidence-Informed Care for Refugee and Migrant Populations**	**ASSESSMENT** ASF-AMB-STD25-v3.0

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

25.5
CORE
L1

THE STANDARD

Evidence-Informed Care for Refugee and Migrant Populations

Staff use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where evidence gaps remain, and adapt practice accordingly — not applying general population guidelines uncritically to a population with documented, different health needs.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are staff aware of evidence-informed guidelines specific to refugee and migrant health where they exist?** *Specific, current awareness, not general clinical knowledge assumed to be sufficient.* Doc: Guideline awareness record	YES	PARTIAL	NO
2	**Do staff recognise where this population's health needs genuinely differ from the general population?** *Genuine, specific recognition, not an assumption that general guidelines always apply equally.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is practice adapted where population-specific evidence indicates a different approach is warranted?** *Actual practice adaptation, not awareness without application.* 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 *Guideline awareness review*	Reviews whether staff have access to and awareness of population-specific evidence-informed guidelines.
ASK *Population-difference interview*	Asks staff to describe a specific way this population's health needs differ from the general population.
OBSERVE *Practice adaptation check*	Checks whether practice genuinely reflects population-specific evidence where it exists.

REFERENCES

[115] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

Standard 25.5 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

Refugee and migrant health needs genuinely differ from the general population in ways that matter clinically — different disease prevalence patterns, different exposure histories, different care-seeking barriers. Care that ignores this and applies general guidelines uncritically can miss real, evidence-based adjustments this specific population needs.

The evidence: [115] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff are aware of and use population-specific evidence-informed guidelines where they exist.	✗ General population guidelines are applied uncritically with no population-specific awareness.
✓ Staff can describe specific, genuine differences in this population's health needs.	✗ Staff cannot describe any specific way this population's needs differ.
✓ Practice is genuinely adapted where population-specific evidence indicates it should be.	✗ Awareness exists but doesn't translate into any actual practice adaptation.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Awareness exists for well-known differences but not for more specific or recent evidence.**
Evidence in this area continues to develop, and awareness needs to stay genuinely current.

2 **Guidelines are known but not consistently applied under time pressure.**
Consistent application under real conditions is what gives awareness genuine protective value.

3 **Evidence gaps are acknowledged but staff default to general population assumptions rather than flagging genuine uncertainty.**
Recognising a genuine gap honestly is different from silently defaulting to a possibly inapplicable assumption.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current awareness of population-specific evidence-informed guidelines.

Week 2 Establish access to current, relevant guidelines for staff.

Week 3 Train staff on specific, genuine population differences relevant to practice.

Ongoing Refresh awareness as evidence in this area develops.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff for a specific example of a practice adaptation based on population-specific evidence.
A real example reveals genuine application, not just familiarity with the concept.

Ask how staff would handle a genuine evidence gap for this population.
A thoughtful, honest answer reveals genuine engagement rather than a default assumption.

E-LEARNING academy.gmj.ge/amb-std25-5-evidence-informed-care — 30 min · complete before self-assessment

	Standard 25.6 NON-NEGOTIABLE · *Standard 25: Refugee & Migrant Health* **Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts**	ASSESSMENT ASF-AMB-STD25-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

25.6
NON-NEGOTIABLE
L1

THE STANDARD

Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

Staff maintain active awareness of their own culture, beliefs, and potential biases through structured reflective practice, and the facility actively fosters a supportive environment with genuine access to psychological support — not assumed self-awareness or an assumption that staff will manage vicarious trauma exposure on their own.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the facility have a structured process for staff reflective practice regarding bias and cultural awareness?** *A defined process, not an assumption that staff will naturally self-reflect adequately.* Doc: Reflective practice process description	YES	PARTIAL	NO
2	**Does the facility provide genuine, accessible psychological support and a real space to discuss difficult cases?** *Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.* Doc: Psychological support and debrief process record	YES	PARTIAL	NO
3	**Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves or colleagues?** *Genuine, concrete examples, not general statements of good intentions or 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 *Reflective practice process review*	Reviews the facility's structured process, if any, for staff reflective practice on bias and cultural awareness.
DOCUMENT *Support and debrief access review*	Reviews what psychological support and debrief structure genuinely exist and whether they are actually used.
ASK *Staff example interview*	Asks a staff member for a specific instance of recognising and adapting for their own bias, and how they handled a recent difficult case.

REFERENCES

[116] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

Standard 25.6 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

Unacknowledged bias shapes clinical judgement in ways that are genuinely hard to see from the inside, and staff providing this care are regularly exposed, secondhand, to accounts of hardship and trauma — both are real, documented occupational realities of this work, and both require structured, deliberate support rather than being left to individual capacity alone.

The evidence: [116] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured reflective practice process genuinely exists and is used, not just assumed.	✗ No structured reflective practice process exists beyond an assumption of individual self-awareness.
✓ Genuine, accessible psychological support exists and staff actually use it.	✗ Psychological support exists only nominally, with no evidence staff actually access it.
✓ Staff can describe specific, real examples of both bias adaptation and vicarious trauma awareness.	✗ Staff cannot describe any specific example of adapting practice or recognising vicarious trauma.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Reflective practice happens informally among some staff but is not structured or clinic-wide.**
Individual good practice does not reliably generalise without a defined, shared process.

2 **Support exists but staff are unaware it is available or feel discouraged from using it.**
A benefit's existence does not guarantee genuine, comfortable access to it.

3 **Difficult cases are discussed informally but there's no routine, structured opportunity for it.**
Vicarious trauma often builds cumulatively, and a structured, regular opportunity provides more reliable support than informal conversation alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current training content and support access for genuine coverage of bias and staff wellbeing.

Week 2 Establish a structured reflective practice process and a real space to discuss difficult cases.

Week 3 Deliver specific training on institutional discrimination and normalise use of available support.

Ongoing Revisit reflective practice and staff wellbeing periodically, using real case examples where appropriate.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific personal example, not a general statement of awareness.
A concrete instance distinguishes genuine reflective practice from familiarity with the concept.

Ask staff directly whether they have used available support, not just whether it exists.
Genuine uptake, not nominal availability, is the real test.

E-LEARNING academy.gmj.ge/amb-std25-6-reflective-practice-and-self-care — 30 min · complete before self-assessment

Standard 25.7 **CORE** · *Standard 25: Refugee & Migrant Health*

Legal Status Diversity Recognition

ASSESSMENT ASF-AMB-STD25-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

25.7
CORE
L1

THE STANDARD

Legal Status Diversity Recognition

The facility can name which legal status categories it actually serves — asylum seeker, recognised refugee, stateless person, internally displaced person, and others — and demonstrates it doesn't apply a single, uniform assumption about access rights across all of them.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Can staff name the specific legal status categories this facility actually serves?** *Specific, named categories, not a general sense that "migrants" are served.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Does the facility avoid applying a single, uniform assumption about access rights across all statuses?** *Genuine differentiation, not treating all categories identically.* Doc: Status-specific access policy documentation	YES	PARTIAL	NO
3	**Is there a specific process for verifying which category applies when it's genuinely unclear?** *A real, defined process, not guesswork or assumption when status is ambiguous.* Doc: Status verification 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	
ASK *Status category awareness interview*	Asks staff to name the specific legal status categories this facility actually serves.
DOCUMENT *Status-specific policy review*	Reviews documentation for genuine differentiation across status categories, not a uniform assumption.
DOCUMENT *Verification process review*	Reviews the process for verifying status when it's genuinely unclear.

REFERENCES

[117] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

Standard 25.7 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

Asylum seeker, recognised refugee, stateless person, and internally displaced person are not interchangeable categories — they carry genuinely different legal access rights in different countries, and treating them as one undifferentiated group risks either wrongly denying care someone is entitled to, or missing a specific vulnerability tied to a particular status.

The evidence: [117] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff can name the specific legal status categories this facility actually serves.	✗ Staff have only a general sense that "migrants" are served, without specific categories.
✓ Policy genuinely differentiates access considerations across status categories.	✗ A single, uniform assumption about access rights is applied regardless of status.
✓ A specific, defined process exists for verifying unclear status.	✗ No process exists for verifying status when it's genuinely unclear.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Staff can name the most common category served but not less frequent ones the facility still encounters.**
Even infrequent categories deserve genuine, specific awareness, not the risk of misapplied assumptions.

2 **Differentiation exists in policy but isn't consistently applied by all staff in practice.**
A policy that exists on paper needs consistent application to provide real protection.

3 **A verification process exists but staff are inconsistently confident applying it.**
A process needs genuine staff familiarity to function reliably under real conditions.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current staff awareness of the specific legal status categories actually served.

Week 2 Build specific, differentiated access guidance for each relevant status category.

Week 3 Establish a clear verification process for genuinely unclear status.

Ongoing Refresh staff awareness periodically, particularly for less frequently encountered categories.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name every specific legal status category the facility has served recently.
Specificity reveals genuine, current awareness rather than a general assumption.

Ask what happens when a patient's specific status is genuinely unclear.
A confident, specific answer reveals a genuine process, not improvisation.

E-LEARNING academy.gmj.ge/amb-std25-7-legal-status-recognition — 30 min · complete before self-assessment

	Standard 25.8 NON-NEGOTIABLE · *Standard 25: Refugee & Migrant Health* **Care Is Documented and Provided Regardless of Immigration or Legal Status**	ASSESSMENT ASF-AMB-STD25-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

25.8
NON-NEGOTIABLE
L1

THE STANDARD

Care Is Documented and Provided Regardless of Immigration or Legal Status

Care is provided and fully documented for every patient regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to patients without documented status.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the same standard of care applied and documented the same way regardless of a patient's immigration or legal status?** *Genuinely equal treatment, not a lesser or informal standard for undocumented patients.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation?** *Specific, documented training, not assumed understanding.* Doc: Staff training record	YES	PARTIAL	NO
3	**Is patient information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information?** *The same confidentiality protection extended to every patient, without exception.* 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 *Care standard observation*	Observes whether care and documentation practice is genuinely consistent regardless of patient status.
DOCUMENT *Staff training review*	Reviews training records confirming staff understand immigration status is never a basis for differential care.
ASK *Confidentiality practice interview*	Asks staff how patient status information, where known, is protected.

REFERENCES

[118] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

Standard 25.8 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

A patient who fears that seeking care will expose their immigration status to consequences may delay or avoid care entirely, and any indication that this facility applies a different standard based on status only reinforces that fear — genuine equal treatment, documented the same way for everyone, is what makes care genuinely accessible to this population.

The evidence: [118] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Care and documentation are genuinely consistent regardless of status.	✗ Care or documentation practice differs based on a patient's known or assumed status.
✓ Staff are specifically trained on this principle, not assumed to understand it.	✗ No specific training addresses this principle.
✓ Confidentiality protection is applied equally without exception.	✗ Status-related information is handled less carefully than other confidential information.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The principle is understood by clinical staff but not consistently by administrative or front-desk staff.**
A patient's first interaction is often with administrative staff, where the same principle needs to hold.

2 **Care is consistent but documentation habits vary informally based on individual staff assumptions.**
Consistency needs to extend to documentation practice specifically, not only the clinical care itself.

3 **The principle is followed but has never been specifically, formally trained.**
Informal understanding is less reliable than specific, documented training, particularly as staff turn over.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for any differential treatment based on status.

Week 2 Establish specific staff training on this principle, covering all staff, not only clinical roles.

Week 3 Confirm documentation practice is genuinely consistent regardless of status.

Ongoing Reinforce training periodically, particularly for new staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask administrative and front-desk staff, not only clinicians, about this principle.
This reveals whether the principle genuinely extends beyond clinical staff.

Ask how patient status information, where it becomes known, is protected.
A specific, confident answer reveals genuine practice, not just a stated value.

E-LEARNING academy.gmj.ge/amb-std25-2-status-neutral-care — 30 min · complete before self-assessment

	Standard 25.9 **CORE** · *Standard 25: Refugee & Migrant Health* **Cross-Border Continuity of Care**	**ASSESSMENT** ASF-AMB-STD25-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

25.9
CORE
L1

THE STANDARD

Cross-Border Continuity of Care

Patients are supported to hold their own health information and documentation in a portable form — paper or electronic — that functions when they move across a border or between health systems, recognising the genuine mobility of refugee and migrant populations.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are patients actively supported to hold their own portable health record, not relying solely on this facility's internal system?** *A genuine, patient-held record, not only an internal system the patient can't access elsewhere.* Doc: Patient-held record support documentation	YES	PARTIAL	NO
2	**Is the patient-held record updated regularly, not provided once and left stale?** *Genuine, ongoing updates, not a one-time document that quickly becomes outdated.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is the record provided in a form usable across different health systems, not tied to this facility's specific format alone?** *Genuinely portable format, not one that only makes sense within this facility's own system.* 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 *Patient-held record review*	Reviews whether patients are genuinely supported to hold a portable health record.
OBSERVE *Record update practice observation*	Checks whether the patient-held record is genuinely updated regularly, not provided once.
ASK *Portability interview*	Asks staff whether the record format would be usable by a different health system or facility.

REFERENCES

[119] WHO's explanatory notes for Competency Standard 1 specifically identify patient-held records — paper or electronic — updated regularly, as a key strategy for improving continuity of care given the mobility of refugee and migrant populations.

Standard 25.9 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

A refugee or migrant patient's mobility isn't a hypothetical edge case — it's a defining feature of the population this standard exists to serve. A record that only exists inside one facility's own system provides no protection the moment that patient needs care somewhere else, which for this population is often exactly when it matters most.

The evidence: [119] WHO's explanatory notes for Competency Standard 1 specifically identify patient-held records — paper or electronic — updated regularly, as a key strategy for improving continuity of care given the mobility of refugee and migrant populations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Patients are genuinely supported to hold their own portable health record.	✗ No patient-held record support exists beyond this facility's internal system.
✓ The record is updated regularly, not provided once and left stale.	✗ A record is provided once but never updated at subsequent visits.
✓ The record format is genuinely usable across different health systems.	✗ The record format only makes sense within this facility's own system.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A patient-held record is provided for major events but not updated for routine visits.**
Continuity depends on the record reflecting the patient's actual, current health picture.

2 **The record exists in paper form but isn't offered in electronic form for patients who would prefer it.**
Different patients have different genuine needs for how they carry their own information.

3 **Staff support the concept but aren't consistent about actually updating the record at each visit.**
Consistent updating is what gives the record real, ongoing protective value.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for patient-held record support and update consistency.

Week 2 Establish a standard, portable record format and offer both paper and electronic options.

Week 3 Brief staff to update the patient-held record consistently at every relevant visit.

Ongoing Audit record currency for a sample of patients holding one.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see an actual patient-held record and check how recently it was updated.
A specific, dated record is the real evidence of genuine, ongoing support.

Ask whether the record format would make sense to a clinician at a different facility.
This tests genuine portability, not just internal usefulness.

E-LEARNING academy.gmj.ge/amb-std25-9-cross-border-continuity — 30 min · complete before self-assessment

	Standard 25.10 **CORE** · *Standard 25: Refugee & Migrant Health* **Follow-Up Systems Account for Housing and Contact Instability**	**ASSESSMENT** ASF-AMB-STD25-v3.0
CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

25.10
CORE
L1

THE STANDARD

Follow-Up Systems Account for Housing and Contact Instability

Follow-up and recall systems have a genuine alternative pathway for patients without a stable address or phone number — community organization contact, in-person scheduling at the next visit, or another real mechanism — not a system that silently fails for any patient whose contact information changes or doesn't exist in the expected form.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a genuine alternative follow-up pathway for patients without a stable address or phone number?** *A real, specific alternative, not an assumption the standard system will eventually work.* Doc: Alternative follow-up pathway document	YES	PARTIAL	NO
2	**Does the system actively identify when standard contact methods have failed, rather than silently losing the patient from tracking?** *Active identification of a failed contact attempt, not passive assumption contact succeeded.* Doc: Failed contact identification process	YES	PARTIAL	NO
3	**Are community organizations or other real intermediaries used as a genuine alternative contact channel where appropriate?** *A genuine, functioning relationship, not a theoretical option never actually used.* Doc: Community organization contact relationship	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 *Alternative pathway review*	Reviews the specific alternative follow-up pathway for patients without stable contact information.
OBSERVE *Failed contact identification check*	Checks whether the system can identify and flag a failed standard contact attempt.
ASK *Community relationship interview*	Asks staff about actual, functioning relationships with community organizations used for alternative contact.

REFERENCES

[120] Follow-up systems accounting for housing and contact instability, distinct from standard address-and-phone-based recall systems, are established practice for maintaining continuity of care with transient and displaced patient populations.

Standard 25.10 · *Standard 25: Refugee & Migrant Health*

Guidance & Learning

GUIDANCE ASF-AMB-STD25-v3.0

WHY THIS STANDARD EXISTS

Standard follow-up systems are typically built assuming a stable address and phone number, and a refugee or migrant patient experiencing housing instability can be entirely invisible to a system built on that assumption — not because the patient doesn't need follow-up, but because the system has no way to reach them.

The evidence: [120] Follow-up systems accounting for housing and contact instability, distinct from standard address-and-phone-based recall systems, are established practice for maintaining continuity of care with transient and displaced patient populations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine alternative follow-up pathway exists for unstable contact situations.	✗ No alternative exists beyond the standard address-and-phone system.
✓ The system actively identifies failed contact attempts, not silently losing track.	✗ Failed contact attempts aren't identified or flagged, patients simply drop from tracking.
✓ Community organization relationships are real and genuinely functioning.	✗ Community organization relationships, if claimed, have never actually been used.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **An alternative pathway exists but isn't consistently offered or explained to patients likely to need it.**
An unexplained option functions similarly to no option for patients who don't know to ask.

2 **Failed contact is sometimes noticed informally but isn't systematically flagged.**
Systematic flagging catches gaps individual staff attention alone can miss.

3 **A community organization relationship exists but hasn't been used recently, so its current functioning is unverified.**
An untested relationship may not translate smoothly into real use when actually needed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current follow-up system for how it handles unstable contact information.

Week 2 Establish a genuine alternative pathway, including community organization relationships where relevant.

Week 3 Build active failed-contact identification into the tracking system.

Ongoing Confirm alternative pathways remain genuinely functional through periodic real use.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example of the alternative pathway being used successfully.
A real example reveals whether this is genuine practice, not a theoretical option.

Ask how the system would notice if a standard follow-up call simply failed to connect.
A specific, confident answer reveals genuine active tracking, not passive assumption of success.

E-LEARNING academy.gmj.ge/amb-std25-3-follow-up-instability — 30 min · complete before self-assessment

References

Numbered references below are formal citations, in Vancouver style, each individually verified against the original source before inclusion. The [N] marker on each criterion's Reference line and "The evidence" line corresponds to its number here.

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

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.

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.

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

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

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

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

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.

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

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.

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.

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

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.

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.

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.

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

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.

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

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

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

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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

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.

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.

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

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

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

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.

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.

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.

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

76. Established radiology practice guidance for performing and interpreting diagnostic computed tomography requires facility dose data to be compared against recognised benchmarks, with protocol review when dose consistently exceeds expected levels.

77. Established MRI safety guidance requires a written safety screening questionnaire reviewed orally with the patient in its entirety immediately prior to entry into the MRI scan area.

78. Consistency of contrast media reaction protocols across all departments within a single facility, rather than independently maintained departmental versions, is established practice for preventing protocol drift as clinical guidance evolves.

79. Failure to track biopsy specimens to a confirmed, communicated result is identified as a specific and serious contributor to delayed melanoma diagnosis in dermatology patient safety literature, distinct in severity from general diagnostic test follow-up.

80. Defined, lesion-appropriate technique and depth protocols for cryotherapy and similar in-office dermatological procedures are established practice for balancing treatment efficacy against the risk of under- or over-treatment.

81. Established dermatology guidelines of care for the management and treatment of psoriasis with phototherapy establish minimal erythema dose or skin-phototype-based initial dosing, with specific dose adjustment rules based on erythema duration following treatment.

82. Defined, timed escalation pathways for suspicious skin lesions, distinct from routine follow-up scheduling, are established practice for minimising diagnostic delay in melanoma and other malignant skin lesions.

83. Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, et al. Allergen immunotherapy: a practice parameter third update. J Allergy Clin Immunol. 2011;127(1 Suppl):S1-55 — establishes a minimum post-injection observation period as a core safety requirement of allergen immunotherapy administration.

84. Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, et al. Allergen immunotherapy: a practice parameter third update. J Allergy Clin Immunol. 2011;127(1 Suppl):S1-55 — establishes dose adjustment for missed doses and prior reactions as a core safety requirement of immunotherapy dose escalation.

85. Correct extract and concentration verification, distinct from and in addition to general patient identification, is established practice for preventing vial mix-up in allergen immunotherapy administration.

86. Murphy RX Jr, Alderman A, Gutowski K, Kerrigan C, Rohrich RJ, Byrd HS, et al. Evidence-based practices for thromboembolism prophylaxis: summary of the American Society of Plastic Surgeons Venous Thromboembolism Task Force Report. Plast Reconstr Surg. 2012;130(1):168e-175e — establishes physician-completed Caprini risk scoring as the standard for VTE prophylaxis decisions in plastic surgery, given documented unreliability of patient self-assessment.

87. Office-based anesthesia safety standards equivalent to hospital-based operating room requirements, including qualified personnel and defined emergency transfer protocols, are established practice for reducing the documented elevated risk associated with office-based surgical anesthesia.

88. Defined, pre-scheduling patient selection criteria for office-based surgical safety, distinct from same-day clinical assessment, are established practice for reducing the documented risk associated with proceeding despite contraindicating patient factors.

89. Established patient safety guidance on reducing the risk for suicide requires validated-tool screening for behavioral health patients, an evidence-based follow-up process for positive screens, and documented risk level with a written mitigation plan.

90. Defined interaction checking and required baseline and ongoing monitoring specific to psychotropic medication classes, distinct from general medication safety practice, is established practice in psychiatric prescribing safety literature.

91. A defined, verified escalation pathway to emergency psychiatric care, distinct from general awareness that emergency services exist, is established practice in outpatient behavioral health crisis management.

92. Established regulatory principles for medications used in the treatment of opioid use disorder, recognized in various forms across many countries, require a written diversion control plan, secure and identifiable take-home medication packaging, and patient education on safe storage and transport.

93. Sullivan JT, Sykora K, Schneiderman J, Naranjo CA, Sellers EM. Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar). Br J Addict. 1989;84(11):1353-1357 — establishes a validated, standardised scale for withdrawal severity assessment, widely adopted as the clinical standard.

94. Specimen temperature verification and defined chain-of-custody procedures are established practice for preventing urine drug screening substitution and tampering in addiction treatment settings.

95. Day LW, Muthusamy VR, Collins J, Kushnir VM, Sultan S, Pannala R, et al. Multisociety guideline on reprocessing flexible GI endoscopes and accessories. Gastrointest Endosc. 2021;93(1):11-33 — requires a written reprocessing policy, model-specific manufacturer training, and documented staff competency prior to independent performance of high-level disinfection or sterilization.

96. Continuous pulse oximetry and capnography monitoring during procedural sedation, combined with specific, validated discharge criteria, are established practice in ambulatory endoscopy safety guidelines for detecting sedation-related respiratory compromise.

97. Failure to track biopsy and polypectomy specimens to a confirmed, communicated pathology result is identified as a specific and serious contributor to delayed colorectal cancer diagnosis in endoscopy patient safety literature, distinct in severity from general diagnostic test follow-up.

98. Institute for Safe Medication Practices. 2025-2026 Targeted Medication Safety Best Practices for Community Pharmacy. Horsham (PA): ISMP; 2025 — specifically addresses obtaining and using an accurate, current patient weight to verify weight-based medication dosing, applicable to medical offices and clinics.

99. Verification of legal decision-making authority, distinct from assumed authority based on who accompanies the child, is established practice in pediatric consent processes given the real variation in custody, guardianship, and family circumstances.

100. Active verification of vaccination status against the current recommended immunization schedule, rather than reliance on unverified parent report, is established practice for identifying and closing immunization gaps in pediatric ambulatory care.

101. WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force when the patient has limited ability to seek a second opinion or negotiate after arrival.

102. Continuity of care across international transitions is identified in cross-border healthcare literature as a distinct risk point, with incomplete or inaccessible record transfer directly linked to preventable post-return complications.

103. Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

104. Patient-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction and perceived safety.

105. Post-operative complication tracking following international medical travel is identified in the medical tourism literature as a systemic gap, with most facilities lacking any mechanism to learn about complications that surface after the patient has returned home.

106. Medical travel facilitation literature identifies documentation delays and errors as a leading cause of care-seeking delay for international patients, with downstream clinical consequences for time-sensitive conditions.

107. Cross-border patient redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international patients face after returning home.

108. Medical tourism governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the treating facility itself.

109. Travel-associated antimicrobial resistance and infection risk is a documented, distinct category in infection prevention literature, with international medical travel specifically identified as a transmission risk pathway requiring targeted screening protocols.

110. Established international travel health guidance recommends against air travel for 10-14 days following major surgery given the combined risk of surgery and air travel for blood clots, including deep vein thrombosis and pulmonary embolism.

111. World Health Organization. Refugee and Migrant Health: Global Competency Standards for Health Workers. Geneva: WHO; 2021 — Competency Standard 3 states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

112. WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

113. WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

114. WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

115. WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

116. WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

117. WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

118. Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

119. WHO's explanatory notes for Competency Standard 1 specifically identify patient-held records — paper or electronic — updated regularly, as a key strategy for improving continuity of care given the mobility of refugee and migrant populations.

120. Follow-up systems accounting for housing and contact instability, distinct from standard address-and-phone-based recall systems, are established practice for maintaining continuity of care with transient and displaced patient populations.

Annex — ISO 9001:2015 Correlation Table

A single-place summary of every criterion's correlation to ISO 9001:2015, for anyone checking this standard's alignment without searching page by page. Criteria not listed here carry no ISO 9001:2015 correlation — this is stated honestly, not implied as a gap in the standard itself; many patient-safety and dignity criteria simply fall outside a quality-management-system standard's scope.

CRITERION	TITLE	ISO 9001:2015
2.5	Waiting and Queue Time Is Actively Managed	**§8 Operation**
3.1	Water Supply Is Safe and Monitored	**§8 Operation**
3.2	Medical Equipment Is Maintained on Schedule	**§7 Support**
3.3	Shared Spaces Are Genuinely Clean	**§8 Operation**
3.4	Facility Risks Are Tracked in One Integrated Register	**§6 Planning**
3.5	Diagnostic Equipment On-Site Is Calibrated, Not Just Maintained	**§7 Support**
3.6	Point-of-Care Testing Has Real Quality Control, Not Just a Working Device	**§8 Operation**
4.2	Staff Credentials Are Checked and Current	**§7 Support**
4.4	Every Patient Gets a Real Assessment	**§8 Operation**
4.5	Medication Prescribing Is Safe	**§8 Operation**
4.6	Patient Identified Correctly at Every Point of Contact	**§8 Operation**
4.7	A Defined, Working Referral Relationship With a Named Receiving Facility	**§8 Operation**
4.8	Referral Follow-Through Is Confirmed, Not Assumed	**§8 Operation**
4.9	Every Test Result Reaches the Patient, Abnormal or Not	**§8 Operation**
4.12	Reusable Equipment Is Cleaned and Sterilised Between Patients	**§8 Operation**
5.2	Basic Resuscitation Equipment Is Ready	**§7 Support**
5.3	Fire Safety Is Real, Not Theoretical	**§7 Support**
6.1	Every Patient Leaves With a Real, Understood Plan	**§8 Operation**
6.2	A Real Mechanism Confirms the Patient Reached Their Next Step	**§8 Operation**
6.3	Patients Can Complain After Leaving, and Complaints Are Read	**§9 Performance Evaluation**
7.1	Leadership Is Real and Accountable	**§5 Leadership**
7.2	Policy Actually Gets Followed	**§7 Support**
7.4	Medical Records Are Complete and Secure	**§7 Support**
7.5	Incidents Are Actually Reported	**§10 Improvement**
7.6	Staff Scope of Practice Is Verified	**§7 Support**
7.7	Leadership Reviews Overall Performance at Planned Intervals	**§9 Performance Evaluation**
7.8	Quality Objectives Are Set, Specific, and Tracked	**§6 Planning**
7.9	A Continual Improvement Process Exists, Not Only Reaction to Individual Incidents	**§10 Improvement**

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