

Ambulatory Clinic Standards — Full Guidance

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 127 criteria.

26 standards · 127 criteria · Version 4.0

Standard 5 — Safety & Emergency Preparedness

4 criteria · 4 non-negotiable · 0 core · Version 3.0

CRITERIA IN THIS STANDARD

- 5.1 — Recognising an Emergency Beyond This Clinic's Capacity
- 5.2 — Basic Resuscitation Equipment Is Ready
- 5.3 — Fire Safety Is Real, Not Theoretical
- 5.4 — Internal Emergency Alerts Are Clear and Trained

5.1 Recognising an Emergency Beyond This Clinic's Capacity

NON-NEGOTIABLE

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

In plain terms: Staff know when a patient is too sick for this clinic and have a fast, defined way to get them to hospital — not a vague plan to 'call someone.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A clinic is not a hospital. The moment a patient's condition exceeds what the clinic can manage — a myocardial infarction, anaphylaxis, a stroke, severe asthma — every minute spent deciding what to do is a minute lost. Staff need to recognise the emergency (training), know the trigger (red flags), and act on a defined pathway (who calls whom, which ambulance, which hospital, what to do while waiting). This is the ambulatory equivalent of the hospital's early warning system: not a score, but a clear line between 'we manage this' and 'this goes to hospital now.'

WHAT GOOD LOOKS LIKE

- Staff have specific, trained recognition criteria.
- A defined, immediate escalation process exists and is followed.
- All clinical staff, not just senior ones, know the process confidently.

COMMON FAILURE MODES

- Recognition relies on general clinical instinct with no specific criteria.
- No defined escalation process exists beyond general expectation.
- Only the most senior staff member present is confident in the process.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic 15 km from the nearest emergency department.

BEFORE

When a patient collapsed with chest pain, the doctor spent 10 minutes deciding whether to send her to hospital while the nurse looked for the ambulance number. She was eventually sent by taxi. There was no red-flag list, no emergency pathway, and no agreed ambulance arrangement.

ACTION

A red-flag list was written for the clinic's case mix (chest pain, breathlessness, altered consciousness, severe bleeding, anaphylaxis, sepsis signs). A one-page emergency pathway: recognise → call ambulance (number posted) → notify receiving hospital (direct line) → start stabilisation per protocol → handover. Staff

completed a half-day emergency recognition course. A quarterly drill was scheduled.

AFTER

The Monitor reviewed the red-flag list, the pathway, training records, and a drill report. Asked two staff what they would do for a patient with chest pain; both described the pathway correctly. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask your staff: what would you do right now if a patient collapsed in the waiting room?
2. Write a red-flag list for your case mix — ten conditions.
3. Write a one-page pathway: recognise, call, notify, stabilise, hand over.
4. Post the ambulance and hospital numbers in every room and run a drill.

The most common mistake: Assuming staff will recognise an emergency and 'know what to do' — without a defined pathway, they hesitate.

SELF-ASSESSMENT QUESTIONS

1. Do staff have specific, trained criteria for recognising a condition beyond this clinic's capacity? — *Specific, trained criteria, not general clinical instinct alone.*

Evidence: Recognition criteria and training record

2. Is there a defined, immediate escalation process once such a condition is recognised? — *A specific, known process, not improvisation in the moment.*

Evidence: Escalation protocol

3. Do all clinical staff, not just senior ones, know this process confidently? — *Genuine, distributed readiness, not knowledge held only by the most experienced person present.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Recognition criteria exist for the most obvious emergencies but not more subtle ones.** — Subtle deterioration is exactly where

recognition gaps matter most.

- **The escalation process is known to physicians but less consistently to support staff.** — An emergency can be first noticed by any staff member, not only clinicians.
- **The process was trained once but never refreshed or drilled since.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current recognition and escalation practice for specificity.
Week 2	Train all clinical and support staff on specific recognition criteria.
Week 3	Establish and brief a defined, immediate escalation process.
Ongoing	Refresh training periodically, including for support staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Recognition criteria review	Reviews the specific, trained criteria for recognising a beyond-capacity condition.
DOCUMENT	Escalation protocol review	Reviews the defined escalation process for completeness and specificity.
ASK	Staff readiness interview	Asks a range of staff, not only senior ones, to describe the escalation process.

SUPERVISOR TIPS

- **Ask a non-physician staff member to describe the escalation process.** — This reveals whether readiness is genuinely distributed, not concentrated in one role.
- **Ask about a subtle, less obvious deterioration scenario.** — Recognition gaps concentrate in less dramatic presentations.

EVIDENCE BASE

[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.

This course teaches practical implementation of this standard. Free to enroll. ASF certificate on completion.

5.2 Basic Resuscitation Equipment Is Ready

NON-NEGOTIABLE

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

In plain terms: The clinic's emergency equipment — oxygen, adrenaline, airway kit, defibrillator if you have one — is checked every day you are open, and staff are current on life support.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

An ambulatory clinic will see an anaphylaxis or a cardiac arrest eventually. Not often — which is exactly why the equipment is expired and the training has lapsed when it happens. The equipment list for a clinic is short: oxygen with a working regulator, adrenaline in date, basic airway adjuncts, a bag-valve mask, and an AED if resources allow. The check is a two-minute tick-list each opening day. The training is BLS for every clinical staff member, refreshed every two years, with a practice drill in between. The clinic that has done all this will save the life; the clinic that has not will watch.

WHAT GOOD LOOKS LIKE

- Daily checks are documented consistently with no gaps.
- Equipment is fully stocked and functional at assessment.

COMMON FAILURE MODES

- Check logs show gaps or inconsistent completion.
- Equipment found during assessment has missing or expired components.

- All relevant staff hold current life support certification.

- One or more staff have lapsed certification with no tracked renewal.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic with an emergency drawer and an AED.

BEFORE

The emergency drawer was checked 'monthly.'
The Coordinator opened it: adrenaline expired four months earlier, oxygen cylinder empty, AED pads expired. BLS certificates: two of six clinical staff current. No one had practised a resuscitation in two years.

ACTION

A daily opening checklist was introduced: oxygen level, adrenaline expiry, airway kit complete, AED ready light. Signed each day. Expired items were replaced and a two-month-ahead expiry reminder set. All clinical staff completed BLS. A mock anaphylaxis drill was run and debriefed.

AFTER

The Monitor checked the drawer unannounced: everything in date and functional, daily checklist signed for six weeks. BLS: 6 of 6 current. Drill report reviewed. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Open your emergency drawer now. Check adrenaline expiry and oxygen level.
2. Pull BLS certificates for every clinical staff member.
3. Start a daily opening checklist — two minutes, signed.
4. Book BLS for anyone lapsed and schedule a drill.

The most common mistake: Checking emergency equipment monthly in a clinic — the emergency happens on the day you didn't check.

SELF-ASSESSMENT QUESTIONS

1. Is resuscitation equipment checked every operating day, with a documented record? — *Every operating day, verifiably, not "regularly."*

Evidence: Daily check log

2. Is all equipment found fully stocked and functional at each check? — *A check that finds gaps but doesn't trigger immediate resupply provides only partial protection.*

Evidence: Gap resolution record

3. Are all relevant staff current on life support certification? — *A lapsed certification discovered during an emergency is a preventable failure.*

Evidence: Certification tracking record

COMMON REASONS FOR A PARTIAL ANSWER

- **Checks happen consistently on weekdays but less reliably on shorter operating days.** — Any day the clinic operates carries the same real risk.
- **Equipment is checked but gaps found aren't resolved before the next operating day.** — Detection without resolution leaves a real gap.
- **Certification tracking exists but renewal reminders aren't proactive.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit check log completeness across all operating days.
Week 2	Establish immediate resolution for any gap found during a check.
Week 3	Build a proactive certification renewal tracking system.
Ongoing	Spot-check readiness periodically, unannounced.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Daily check log review	Reviews check logs for consistency across operating days.

Method	What	Detail
OBSERVE	Live equipment check	Directly inspects equipment for stock completeness and functionality.
DOCUMENT	Certification currency check	Reviews staff certification records for lapses.

SUPERVISOR TIPS

- **Check logs for the clinic's shortest or least busy operating days specifically.** — Routine checks can erode exactly when the day feels less demanding.
- **Physically inspect equipment yourself rather than relying on the log alone.** — A completed log entry and genuinely current equipment aren't always the same thing.

EVIDENCE BASE

[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.

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5.3 Fire Safety Is Real, Not Theoretical

NON-NEGOTIABLE

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

In plain terms: Fire extinguishers, alarms, and exits are tested on schedule, and an evacuation drill has actually been run with real staff participation.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Clinic fires kill patients who cannot walk. Every year, fires in clinics with untested alarms, blocked exits, and staff who have never practised evacuation cause deaths that a functioning system would have prevented. Equipment testing is the easy part — a contractor does it. The hard part is the drill: moving bedridden patients, horizontal evacuation to the next fire compartment, knowing who counts heads. Staff who have done it once, even in a drill, act; staff who have only read the policy freeze.

WHAT GOOD LOOKS LIKE

- Equipment is tested on a consistent, documented schedule.
- A real evacuation drill has been run, with genuine participation.
- Evacuation routes are verified clear.

COMMON FAILURE MODES

- Testing records show gaps or don't exist.
- No evidence of an actual physical drill, only a written plan.
- Routes are found obstructed by stored equipment or furniture.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic in a four-storey building.

BEFORE

Extinguishers had inspection tags dated 18 months earlier. Two fire exits on the third floor were locked with a chain 'to prevent theft.' The alarm had not been tested in a year. No evacuation drill had been run since the building opened. Staff could not say how they would move ICU patients.

ACTION

A fire safety contract was renewed with monthly alarm tests and annual extinguisher service. Chains were removed; exits fitted with alarmed push bars. A horizontal evacuation plan was written per floor. A drill was run on the third floor with 10 volunteer 'patients,' including two on

beds. The debrief identified that the fire doors did not close automatically; this was fixed.

AFTER

The Monitor found all exits clear and alarmed, extinguishers in date, alarm test log current. Reviewed the drill report. Asked an ICU nurse how she would evacuate; she described horizontal evacuation to the adjacent compartment. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk every fire exit today and try to open it. Any locked or blocked exit is an emergency.
2. Check extinguisher tags — are they in date?
3. Find out when the alarm was last tested.
4. Schedule a drill on one floor this month, with beds.

The most common mistake: Locking fire exits to stop theft or unauthorised access — this has killed patients in clinic fires worldwide.

SELF-ASSESSMENT QUESTIONS

1. Is fire safety equipment tested on a defined schedule, with records kept? — *Extinguishers and alarms specifically, not general assumption of functionality.*

Evidence: Fire equipment testing log

2. Has an evacuation drill actually been run, with real staff participation? — *A physical drill, not a tabletop discussion of the plan.*

Evidence: Drill record, date and scope

3. Are evacuation routes kept genuinely clear, not obstructed in practice? — *A route clear on paper but blocked in reality fails when it matters.*

Evidence: Route clearance check

COMMON REASONS FOR A PARTIAL ANSWER

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

- **A drill was run once, historically, with no repeat since.** — Staff turnover means a single historical drill doesn't reflect current readiness.
- **Routes are clear during quiet periods but accumulate obstruction over time.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit fire safety equipment testing records for consistency.
Week 2	Schedule and run a genuine evacuation drill if none has occurred recently.
Week 3	Establish a routine evacuation route clearance check.
Ongoing	Repeat drills on a fixed schedule.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **Ask for the drill date and who participated.** — Specific, dated evidence is the only real proof of practice.
- **Walk the evacuation routes yourself.** — Obstruction accumulates gradually and may not be visible from records alone.

EVIDENCE BASE

[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.

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5.4 Internal Emergency Alerts Are Clear and Trained

NON-NEGOTIABLE

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

In plain terms: The clinic has a defined emergency alert — how staff summon help for a collapse, a fire, a threat — and everyone, including reception, knows it.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

In a clinic, the person who sees the emergency first is often the receptionist or the cleaner. If the alert is 'shout for the doctor,' the doctor may be in a soundproofed room with another patient. A defined alert — a bell, a phrase over the intercom, a panic button — reaches everyone immediately and tells them what kind of emergency it is. Two or three alert types are usually enough for a clinic: medical emergency, fire, security. Everyone must know them, including part-time and new staff. Test them.

WHAT GOOD LOOKS LIKE

- A clear, documented system exists.
- All staff categories are trained on this specific system.
- Staff correctly state the required response for each alert type.

COMMON FAILURE MODES

- No documented system exists.
- Training reaches full-time staff but not part-time or covering staff.
- Staff recognise an alert occurred but cannot state the correct response.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic across two floors with no alert system.

BEFORE	When a patient collapsed in the upstairs waiting area, the receptionist ran downstairs to find a doctor. Ninety seconds were lost. There was no bell, no intercom, no agreed phrase. New staff were not told anything about emergencies.
ACTION	A wireless panic button was installed at reception and in each waiting area, sounding a distinct tone throughout the clinic. Three plain-language alerts were agreed: 'Medical emergency, [location],' 'Fire — evacuate,' 'Security — [location].' A card was posted in every room and given to every staff member. The alert was tested monthly and added to induction.
AFTER	The Monitor asked five staff including a part-time receptionist what the tone means and what they do; all answered correctly. Observed a test. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask your receptionist how they would summon a doctor if a patient collapsed in front of them.
2. Install a simple alert — a wireless bell or intercom.
3. Agree three plain-language alerts and post them in every room.
4. Test monthly and include in induction.

The most common mistake: Relying on shouting in a building with closed consulting room doors.

SELF-ASSESSMENT QUESTIONS

1. Does the clinic have a clearly documented internal emergency alert system? — *A specific, written system, not an assumption staff will understand from prior experience elsewhere.*

Evidence: Internal emergency alert system document

2. Are all staff, including part-time or covering staff, trained on this specific system? — *Facility-specific training, not reliance on what a code meant at a previous workplace.*

Evidence: Training record covering all staff categories

3. Can staff correctly state the required response for each alert type used? — Understanding the required response, not just recognising an alert occurred.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The system is understood by clinical staff but not administrative staff who may also need to respond. —**
Emergency response often depends on more than clinical staff alone.
- **Training happens at induction but is never refreshed. —** Recall fades without periodic reinforcement.
- **The system is clear for common alerts but less clear for rare ones.**

IMPLEMENTATION PLAN

When	What
Week 1	Document the clinic's internal emergency alert system clearly.
Week 2	Extend training to all staff categories, including part-time and covering staff.
Week 3	Consider a plain-language approach to reduce confusion given staff turnover.
Ongoing	Refresh training periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Alert system documentation review	Reviews the documented system for clarity and completeness.
ASK	Staff response interview	Asks staff, including part-time staff, what a specific alert means and requires.
DOCUMENT	Training coverage check	Reviews training records for coverage across all staff categories.

SUPERVISOR TIPS

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

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

EVIDENCE BASE

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

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← **Ambulatory Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 4 — Care & Treatment**

Standard 6 — Aftercare & Follow-up →

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Standard 6 — Aftercare & Follow-up

3 criteria · 2 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

6.1 — Every Patient Leaves With a Real, Understood Plan

6.2 — A Real Mechanism Confirms the Patient Reached Their Next Step

6.3 — Patients Can Complain After Leaving, and Complaints Are Read

6.1 Every Patient Leaves With a Real, Understood Plan

NON-NEGOTIABLE

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

In plain terms: Every patient leaves with a written plan they understand — what to do, what to take, when to come back, when to worry — and can tell you in their own words.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The consultation ends and the patient walks out with a prescription and a vague memory. Half of what was said is forgotten by the car park. Without a written plan the patient can hold, the medication is taken wrong, the follow-up is missed, the warning sign is ignored. A plan is not a leaflet; it is a short personalised note — medication, dose, when to return, three warning signs, who to call — explained, and confirmed by asking the patient to say it back. This is the single most effective way to reduce return visits for the same problem.

WHAT GOOD LOOKS LIKE

- Every patient receives a documented, patient-specific plan.
- Patients contacted afterward can accurately describe it.
- Plans consistently cover medication, warning signs, and contact information.

COMMON FAILURE MODES

- Aftercare information is a generic printed sheet regardless of the actual visit.
- Patients contacted afterward cannot describe what they were told.
- Plans are missing key elements like warning signs or contact information.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic where consultations ended with a verbal explanation and a prescription.

BEFORE

The Coordinator phoned ten patients the day after their visit. Four were unsure how to take their medication. Three did not know when to return. Six could not name a warning sign. Two had returned to the clinic for the same problem within a week.

ACTION

A one-page 'Your plan' sheet was created: diagnosis in plain words, medications with dose and timing, follow-up date, three warning signs, clinic phone number. Completed by hand or printed at the end of every consultation. The clinician asks: 'Can you tell me what you'll do?'

and notes the answer. Time added per consultation: three minutes.

AFTER

The Monitor phoned ten recent patients: all could describe their medication, follow-up, and at least two warning signs. Same-problem return visits down 40%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Phone five patients from yesterday: do they know how to take their medicine and when to worry?
2. Create a one-page plan template.
3. Complete it for every patient and ask them to say it back.
4. Add three minutes to each consultation slot.

The most common mistake: Giving the patient a leaflet about their condition instead of a plan about what they should do.

SELF-ASSESSMENT QUESTIONS

1. Does every patient receive a documented aftercare plan specific to their visit? — *Content specific to this patient's condition, not a generic sheet.*

Evidence: Aftercare plan sample

2. Can a patient contacted after the visit explain their own plan in their own words? — *Tests whether the plan was actually understood, not just handed over.*

Evidence: N/A — tested directly, e.g. follow-up call

3. Does the plan cover medication, warning signs, and who to contact if something goes wrong? — *A plan missing any of these leaves a genuine gap in what the patient needs.*

Evidence: Plan content checklist

COMMON REASONS FOR A PARTIAL ANSWER

- **Plans are individualised for complex visits but generic for routine ones.** — Perceived complexity often determines effort, though routine visits still carry real risk.
- **The plan is thorough but delivered in the last rushed moments before the patient leaves.** — Content quality doesn't matter if delivery doesn't allow genuine understanding.

- **Plans are given to the patient but not to an accompanying caregiver when relevant.**

IMPLEMENTATION PLAN

When	What
Week 1	Review a sample of recent aftercare plans for genuine patient-specific content.
Week 2	Build plan delivery into the visit schedule with real time allocated.
Week 3	Train staff to check patient understanding before the patient leaves.
Ongoing	Spot-check patient understanding through follow-up contact.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Plan content review	Reviews a sample of aftercare plans for patient-specific content.
ASK	Patient understanding check	Contacts a recent patient to check whether they can describe their own plan accurately.
OBSERVE	Delivery process observation	Observes how aftercare instructions are actually delivered.

SUPERVISOR TIPS

- **Contact a discharged patient directly if possible.** — The document proves content existed; the patient's recall proves it was understood.
- **Observe an actual discharge if timing allows.** — Rushed delivery is a common, specific failure pattern worth seeing directly.

EVIDENCE BASE

[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.

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6.2 A Real Mechanism Confirms the Patient Reached Their Next Step

NON-NEGOTIABLE

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

In plain terms: For every referral or follow-up, someone checks the patient actually got there — a defined process, not something that happens only if the patient phones you.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is the follow-through counterpart of 4.8. The clinic’s responsibility does not end when the patient leaves; it ends when the patient has reached the next step — the specialist appointment, the test, the review. Patients fall through gaps in every system, and clinics that do not check never know who fell. The mechanism can be simple: a log, a phone call at a defined interval, a return form from the receiving facility. It must be routine, not reactive. The patient who most needs the follow-up is the one least likely to chase it.

WHAT GOOD LOOKS LIKE

- A defined, proactive mechanism is applied consistently.
- Completion is tracked and verifiable, not dependent on memory.
- A clear escalation path exists and is used when a

COMMON FAILURE MODES

- Follow-up happens only if the patient calls back.
- No tracking confirms follow-up actually happened.
- Staff are uncertain what to do if follow-up reveals a gap.

gap is found.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic sending 60 patients a month for tests, specialist review, or return visits.

BEFORE	Follow-up was the patient's responsibility. No log existed. The Coordinator sampled 25 patients told to return in two weeks; 11 had not. Three of those had conditions that warranted review. Nobody had noticed.
ACTION	A follow-up log was created alongside the referral log: every patient given a return date or referral is entered; the log is checked weekly for missed dates; a phone call is made within three days of any missed follow-up; outcomes are recorded. The receptionist owns the log; the Coordinator audits it monthly.
AFTER	The Monitor reviewed three months of the log: 180 entries, 92% attended, 14 recovered by phone call. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every patient told to return or referred in the last month.
How many did?
2. Start a follow-up log with expected dates.
3. Assign one person to check it weekly and phone anyone who missed.
4. Record what happened.

The most common mistake: Assuming the patient will come back if it matters — the patient does not always know it matters.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined mechanism to actively confirm patients reached their referral or follow-up, not just availability on request? — *The*

clinic initiating contact, not merely being reachable if the patient calls first.

Evidence: Follow-up protocol document

2. Does the mechanism apply consistently, not only for cases staff happen to remember? — *A system that depends on individual staff memory is not a reliable system.*

Evidence: Follow-up completion log

3. Is there a defined escalation if follow-up reveals the patient never went? — *Detecting a gap is only useful if something happens as a result.*

Evidence: Escalation protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Follow-up happens reliably for high-risk referrals but inconsistently for routine ones.** — Routine referrals still carry genuine risk of a missed step.
- **A follow-up call is made but doesn't ask specific enough questions to confirm completion.** — A generic check-in may miss whether the patient actually went.
- **Follow-up is attempted but not repeated if the patient doesn't answer the first call.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent referrals for evidence of actual follow-up contact.
Week 2	Define a specific follow-up mechanism, timing, and content.
Week 3	Build a tracking log so completion is verifiable.
Ongoing	Review the escalation protocol periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Follow-up protocol and log review	Reviews the mechanism and checks completion records against actual recent referrals.
OBSERVE	Follow-up contact sample check	Checks whether a sample of recent patients actually received the defined follow-up contact.

Method	What	Detail
ASK	Escalation protocol interview	Asks staff what happens if follow-up reveals the patient never went.

SUPERVISOR TIPS

- **Ask for a completion log, not a description of the intended process.** — A tracked record is the only real evidence.
- **Ask about retry attempts for patients who don't answer the first call.** — The hardest-to-reach patients are sometimes the highest-risk ones.

EVIDENCE BASE

[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.

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6.3 Patients Can Complain After Leaving, and Complaints Are Read CORE

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

In plain terms: Patients can complain after they have left — by phone, email, or web — someone reads every complaint, and at least one thing has changed because of one.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A complaint from a patient who has left is the clinic's most honest feedback: they have nothing to gain and no pressure to be polite. A complaints box in the waiting room captures none of it. The

mechanism must work from outside — a number on the plan sheet, an email, a form on the website — and must lead somewhere: a named person who logs, acknowledges, investigates, and responds. Then the harder part: connecting complaints to improvement. The standard asks for evidence of at least one change. If nothing has ever changed, the complaints process is a filing system.

WHAT GOOD LOOKS LIKE

- A clear, accessible channel exists for patients after they've left.
- Sampled complaints show genuine responses.
- At least one documented instance exists of a complaint leading to change.

COMMON FAILURE MODES

- No channel exists beyond an in-person suggestion box.
- Complaints are collected but show no evidence of response.
- Nobody can recall a complaint ever leading to change.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic with a feedback box at reception.

BEFORE

The box received two notes a year. There was no other route. A patient who phoned to complain about a missed diagnosis was told to 'come in and speak to the manager.' She did not. The clinic had no complaint log and had never changed anything as a result of feedback.

ACTION

A complaints email and direct phone line were created and printed on every plan sheet. The practice manager logs each complaint, acknowledges within 3 working days, and responds within 20. Complaints are reviewed at the monthly team meeting. A 'You said, we changed' notice went up in the waiting room.

AFTER

The Monitor reviewed the log: 14 complaints in six months, all responded to; three changes made and posted. Interviewed a patient whose

complaint about waiting times had led to a change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Try to complain about your clinic from home. Can you?
2. Put an email and phone number on every patient's plan sheet.
3. Name one person to log and respond to every complaint.
4. Find one complaint that should have changed something — and change it.

The most common mistake: Having a feedback box that no one empties and calling it a complaints process.

SELF-ASSESSMENT QUESTIONS

1. Can a patient submit a complaint after leaving, not only while present? — *A way to reach the clinic afterward, not only an in-person suggestion box.*

Evidence: Complaint channel description

2. Is there evidence complaints are actually read and result in a response? — *A collected complaint with no follow-through provides no real value.*

Evidence: Complaint response record sample

3. Have any complaints led to a documented change in practice? — *A system that has never led to a change is worth questioning.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A channel exists but isn't clearly communicated to patients before they leave.** — Availability patients don't know about functions like unavailability.
- **Complaints receive acknowledgment but not a substantive response.** — A form-letter acknowledgment can satisfy the letter without real value.
- **Serious complaints are reviewed; minor ones accumulate without individual response.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current channel accessibility, particularly for patients who've left.
Week 2	Ensure the channel is clearly communicated as part of the visit.
Week 3	Establish a defined response process and timeframe.
Ongoing	Track whether complaints lead to real practice changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Post-visit channel accessibility check	Verifies a real, accessible way exists for a patient to submit a complaint after leaving.
DOCUMENT	Response record review	Reviews complaints for evidence of an actual response.
DOCUMENT	Practice-change history check	Checks for any documented instance where a complaint led to a change.

SUPERVISOR TIPS

- **Ask how a patient would actually find and use the channel.** — Theoretical availability and genuine accessibility aren't always the same.
- **Ask for a specific example of a complaint that changed something.** — A real example reveals more than a description of the process.

EVIDENCE BASE

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

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← **Ambulatory Clinic
Standards — all standards**

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**Standard 7 — Governance &
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ASF STANDARDS · AMBULATORY CLINIC · STANDARD 7

Standard 7 — Governance & Management

10 criteria · 6 non-negotiable · 4 core · Version 3.1

CRITERIA IN THIS STANDARD

- 7.1 — Leadership Is Real and Accountable
 - 7.2 — Policy Actually Gets Followed
 - 7.3 — Patient Information Stays Private
 - 7.4 — Medical Records Are Complete and Secure
 - 7.5 — Incidents Are Actually Reported
 - 7.6 — Staff Scope of Practice Is Verified
 - 7.7 — Leadership Reviews Overall Performance at Planned Intervals
 - 7.8 — Quality Objectives Are Set, Specific, and Tracked
 - 7.9 — A Continual Improvement Process Exists, Not Only Reaction to Individual Incidents
 - 7.10 — Patient Feedback Has an Independent Channel, Not Just an Internal One
-

7.1 Leadership Is Real and Accountable

NON-NEGOTIABLE

The clinic has clear, named clinical and operational leadership with defined authority over safety and quality, clinical governance, and financial stewardship — not an informal arrangement functioning without real oversight structure. The clinic documents its mission, values, and a code of conduct for staff behaviour, genuinely guiding resourcing and staff conduct.

In plain terms: The clinic has named clinical and operational leaders with written authority over safety and quality — not just an owner who decides things informally.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

Even a small clinic needs someone accountable for safety who is not only the owner. Clinical leadership decides what care is acceptable; operational leadership makes sure the systems work. When these are one undefined person, or when they are informal, decisions about safety compete with decisions about revenue with no one whose job is to protect the patient. Named leadership with written authority — a clinical lead, a practice manager, defined responsibilities — creates the structure. It need not be elaborate; it needs to exist and be known.

WHAT GOOD LOOKS LIKE

- A named person holds clear, defined safety and quality authority.
- This person actively engages with real quality and safety matters.
- Staff know a specific pathway for raising a safety concern.

COMMON FAILURE MODES

- No specific person holds this authority; it's informally diffuse.
- Leadership engagement is limited to administrative matters.
- Staff are unsure how a safety concern would ever reach leadership.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic owned by a physician who made all decisions.

BEFORE	There was no clinical lead role, no practice manager, no defined responsibilities. Quality issues were raised with the owner if someone thought of it. When a medication error occurred, no one was sure whose job it was to review it. Staff described the structure as 'whoever the doctor tells.'
ACTION	The owner designated himself clinical lead and appointed the senior nurse as practice manager, with a one-page terms of reference for each: what they decide, what they review, what they report. A monthly leadership meeting was set with a standing safety item. The medication error was reviewed and an action taken.
AFTER	The Monitor reviewed the terms of reference, minutes of four monthly meetings with safety items and actions, and interviewed the practice manager who described her authority. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Write down who is responsible for clinical quality and who for operations. If it is the same undefined person, that is the gap.
2. Give each role a one-page terms of reference.
3. Set a monthly leadership meeting with safety first on the agenda.
4. Tell the staff who does what.

The most common mistake: Assuming the owner's involvement is governance — governance is a structure, not a person.

SELF-ASSESSMENT QUESTIONS

1. Is there a named person with defined authority over clinical safety and quality? — *A specific name and defined authority, not an informal arrangement.*

Evidence: Leadership structure document

2. Does this person actively review quality and safety matters, not only administrative ones? — *Genuine engagement with quality, not administration alone.*

Evidence: Quality review record

3. Is there a documented process for raising a safety concern to this leadership? — *A specific, known pathway, not an assumption someone would eventually hear about it.*

Evidence: Escalation pathway document

4. Is clinical governance — oversight of clinical effectiveness, audit, and risk — explicitly assigned as a named leadership responsibility? — *A distinct, named accountability, not assumed to be covered by discussing quality in general terms.*

Evidence: Leadership role definitions

5. Is financial stewardship a defined leadership responsibility distinct from day-to-day financial administration? — *Real oversight of budget and financial risk, not only operational bookkeeping.*

Evidence: Leadership role definitions

6. Does the clinic have a documented mission, values, and code of conduct, genuinely guiding resourcing decisions and expected staff behaviour? — *Specific enough to guide real decisions and conduct, not generic text that could apply to any clinic anywhere.*

Evidence: Mission/values/code of conduct document

COMMON REASONS FOR A PARTIAL ANSWER

- **A named leader exists but spends most time on clinical duties, with little time for oversight.** — A title without real time devoted to the function provides limited real oversight.
- **An escalation pathway exists but has never actually been used or tested.** — An untested pathway may not translate smoothly into real use.
- **Leadership reviews quality data but rarely acts visibly on findings.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm and document named leadership and defined authority.

When	What
Week 2	Establish a specific, communicated escalation pathway for safety concerns.
Week 3	Build genuine time for quality and safety oversight into leadership's role.
Ongoing	Track leadership follow-through on identified issues.
	For Micro (solo) Write a single, dated statement naming yourself as the accountable person for safety and quality at this practice, and set a recurring time on your own calendar to actually act on it — this alone satisfies the requirement genuinely.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Leadership structure review	Reviews the named leadership structure and defined authority.
ASK	Leadership engagement interview	Asks the named leader to describe a recent quality or safety issue they addressed.
OBSERVE	Escalation pathway check	Checks whether staff know how to raise a safety concern to leadership.

SUPERVISOR TIPS

- **Ask the named leader for a specific, real example of addressing a safety issue.** — A real example reveals genuine engagement versus a title alone.
- **Ask front-line staff how they'd escalate a concern.** — Staff-side confirmation reveals whether the pathway genuinely functions.

EVIDENCE BASE

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

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7.2 Policy Actually Gets Followed

NON-NEGOTIABLE

A policy framework exists and staff can describe how it's genuinely applied in practice, not merely confirm that policies are filed and technically available. Every policy, procedure and plan is formally authorised by a named person and reviewed on a defined schedule.

In plain terms: Policies exist, and staff can describe how they actually apply them in real situations — not just confirm the binder is on the shelf.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Every clinic has policies. Most sit in binders or on shared drives, written for accreditation, never read. A policy that is not known is not a policy; it is a document. The test is whether a nurse on the treatment area can say what the hand hygiene policy requires of her, or what the medication policy says to do about a verbal order. If she can, the policy is alive. If she has to look it up, or does not know it exists, the clinic's actual practice is whatever each person decides. The standard asks for evidence of application, not existence.

WHAT GOOD LOOKS LIKE

- Staff describe genuine application of policy in their actual work.
- A real adherence-checking mechanism exists.
- Identified gaps trigger a defined, followed response.

COMMON FAILURE MODES

- Staff confirm policies exist but cannot describe how they apply.
- No mechanism exists to verify adherence beyond filing.
- Known gaps persist without any response.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic with 180 policies on a shared drive.

BEFORE

The Coordinator asked ten staff to describe three policies relevant to their role. Two could describe one policy. Most did not know where policies were kept. Several policies contradicted current practice; some referred to departments that no longer existed. The last review date on most was five years earlier.

ACTION

The policy set was reduced to 40 essential documents, each two pages or less. Each had a named owner and a review date. Every policy was linked to a training or briefing: the ten most critical (hand hygiene, medication, identification, consent, incident reporting) were covered at induction and annual refresher. A monthly 'policy of the month' briefing was added to treatment area meetings.

AFTER

The Monitor asked eight staff to describe two policies relevant to their role; seven could. Reviewed the policy register with owners and dates. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five staff to describe one policy they follow daily. Note how many can.
2. Count your policies. If over 60, most are unread.
3. Reduce to the essential set, each two pages, each with an owner.
4. Link every critical policy to a training moment.

The most common mistake: Producing more policies to satisfy an audit when the problem is that existing ones are unknown.

SELF-ASSESSMENT QUESTIONS

1. Can staff describe how a specific, named policy is actually applied in their daily work? — *Not whether they know a policy exists — whether they can describe applying it.*

Evidence: N/A — tested directly

2. Is there a mechanism to check policy adherence, not just policy existence? — *A genuine audit or spot-check process, distinct from confirming documents are filed.*

Evidence: Policy adherence audit record

3. When a policy-practice gap is found, is there a defined response? — *Identifying a gap without addressing it provides limited real value.*

Evidence: Gap resolution record

4. Is every policy, procedure and plan formally authorised by a named person with the authority to approve it, genuinely recorded? — *A recorded sign-off by someone with real authority, not a document that simply appeared with no traceable approval.*

Evidence: Document approval record

5. Is every policy, procedure and plan reviewed against a defined timescale to confirm it's still current? — *A genuine scheduled review date, not a document approved once and never revisited.*

Evidence: Document review schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **Policies are followed for established practices but not consistently for newer ones.** — Habit reinforces old adherence; new policies need active reinforcement.
- **An adherence check exists but only samples an easily-prepared subset.** — A narrow or predictable scope can miss where real gaps live.
- **Gaps are identified but corrective action isn't tracked to completion.**

IMPLEMENTATION PLAN

When	What
Week 1	Select key policies and ask a sample of staff to describe actual application.
Week 2	Establish a genuine adherence-checking mechanism.

When	What
Week 3	Build a tracked resolution process for identified gaps.
Ongoing	Rotate which policies get checked.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff application interview	Asks staff to describe how they actually apply a specific named policy.
DOCUMENT	Adherence audit review	Checks for evidence of a process verifying policy adherence.
OBSERVE	Practice-policy comparison	Observes an area and compares actual behaviour against stated policy.

SUPERVISOR TIPS

- **Ask about application, not existence.** — These surface very different answers.
- **Pick a policy area to observe directly, not just review on paper.** — Direct observation reveals gaps document review cannot.

EVIDENCE BASE

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

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7.3 Patient Information Stays Private

NON-NEGOTIABLE

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

In plain terms: Patient information is kept private in practice — no charts left open, no conversations in corridors, no screens visible to visitors — not just in a policy.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Confidentiality is broken by habit, not malice: the chart on the trolley in the corridor, the diagnosis discussed at the nurses' station within earshot of the waiting room, the computer screen facing the door, the whiteboard listing every patient's condition. Each one is a small betrayal that patients notice and remember. In some contexts — HIV, mental illness, pregnancy — a breach can end a marriage, a job, or a life. The policy is the easy part. The hard part is the culture: a clinic where staff automatically lower their voices and close the chart because that is simply what one does.

WHAT GOOD LOOKS LIKE

- Screens are consistently positioned away from public view.
- Clinical conversations happen in genuinely private spaces.
- Staff describe habitual privacy practices without prompting.

COMMON FAILURE MODES

- Screens face waiting areas, visible to anyone passing.
- Conversations are regularly audible to other patients.
- Staff can cite policy but describe no specific habits.

WORKED EXAMPLE

IN PRACTICE

A 8-room clinic with a written confidentiality policy.

BEFORE

The Coordinator walked the treatment areas: charts open on trolleys in public corridors; a whiteboard at the nurses' station listing patient names and diagnoses visible from the lift; a doctor discussing a patient's HIV result with a colleague in the waiting area. Computer screens

	at reception faced the queue. Staff had signed the policy at induction.
ACTION	Whiteboards were moved behind the station or replaced with initials only. Chart trolleys were fitted with covers. Computer screens were turned and fitted with privacy filters. A 'quiet room' was designated on each treatment area for sensitive conversations. A 10-minute confidentiality-in-practice briefing with real examples was added to treatment area meetings. Monthly walk-rounds by the treatment area manager checked for breaches.
AFTER	The Monitor walked three treatment areas: no open charts, no visible diagnoses, screens shielded. Observed a doctor take a family into the quiet room for a difficult conversation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk through your clinic as a visitor. What patient information can you see or hear?
2. Turn every screen away from public view.
3. Remove diagnoses from any board visible to visitors.
4. Designate a room on each treatment area for private conversations.

The most common mistake: Having every staff member sign a confidentiality policy while the whiteboard in the corridor lists every patient's diagnosis.

SELF-ASSESSMENT QUESTIONS

1. Are screens and monitors positioned so patient information isn't visible to others? — *Physical positioning, checked directly.*

Evidence: Photo audit of screen positioning

2. Are clinical conversations conducted where they can't be overheard? — *Doors or private spaces genuinely used, not just available.*

Evidence: N/A — tested directly

3. Do staff apply confidentiality practices consistently, not only when reminded? — *Habitual, not situational.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Physical privacy is good in exam rooms but overlooked at the reception counter.** — Privacy protection is often strongest where it was deliberately designed.
- **Staff are conscientious when reminded but inconsistent otherwise.** — Habitual practice is more reliable than reminded practice.
- **A private space exists but isn't consistently used under time pressure.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit screen positioning and conversation privacy across all patient-facing areas.
Week 2	Reposition screens and reinforce private space use where gaps are found.
Week 3	Brief staff on habitual, not just reminded, confidentiality practice.
Ongoing	Spot-check physical privacy periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Physical privacy check	Walks through patient-facing areas checking screen positioning and conversation privacy.
OBSERVE	Conversation audibility check	Checks whether conversations can be overheard from adjacent areas.
ASK	Staff practice interview	Asks staff to describe specific privacy practices.

SUPERVISOR TIPS

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

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

EVIDENCE BASE

[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.

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7.4 Medical Records Are Complete and Secure

NON-NEGOTIABLE

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

In plain terms: Medical records are complete (audited regularly), and protected by access controls and a breach plan.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This combines two hospital criteria (7.5 and 7.6) for the clinic setting. Records must contain the mandatory elements — identification, history, examination, diagnosis, plan, consent where relevant — and a monthly audit of a sample is the only way to know they do. Records must also be secure: individual logins, locked paper storage, and a one-page plan for what to do when a breach happens. A clinic with a shared computer login and an unlocked filing cabinet has neither.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Regular, genuine completeness audits are conducted.
- Access controls are genuinely role-based.
- A specific, actionable breach response plan exists.

- No audit process exists, or completeness is assumed.
- Data access is broadly available regardless of role.
- No breach response plan exists beyond vague concern.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic with an electronic record system and a paper archive.

BEFORE

All staff used one login. The paper archive was in an unlocked cupboard in a corridor. No one audited records. The Coordinator pulled 20 records: 8 lacked a documented plan; 5 lacked examination findings; 3 had no allergy status. There was no breach plan.

ACTION

Individual logins were created with role-based access. The archive was moved to a locked room with a key register. A monthly audit of 15 records against a 10-item checklist was started, with results shared with clinicians. A one-page breach plan was written. Two staff completed a data protection briefing.

AFTER

The Monitor reviewed four months of audits (completeness up from 62% to 90%), the access list, the key register, and the breach plan. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count shared logins. Any above zero is a gap.
2. Lock the paper records and start a key register.
3. Pull 15 records and check 10 mandatory items.
4. Write a one-page breach plan.

The most common mistake: Trusting the electronic template to make records complete while everyone logs in as 'admin.'

SELF-ASSESSMENT QUESTIONS

1. Is there a defined list of mandatory record elements, audited regularly? — *A specific, checkable list and genuine audit, not assumed completeness.*

Evidence: Mandatory elements list and audit record

2. Are access controls in place restricting data access to staff who need it for their role? — *Role-based restriction, not general access available to anyone.*

Evidence: Access control policy and implementation

3. Is there a documented, specific breach response plan? — *A named process, not a general statement of concern.*

Evidence: Breach response plan document

COMMON REASONS FOR A PARTIAL ANSWER

- **Audits happen but only sample a small, unrepresentative set of records.** — A narrow sample can miss where real gaps concentrate.
- **Access controls exist for electronic records but not physical files.** — Security attention often concentrates on digital systems.
- **A breach plan exists but has never been reviewed since written.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the mandatory elements list and recent audit practice.
Week 2	Establish a genuine, regular completeness audit.
Week 3	Review access controls against actual staff roles.
Ongoing	Review the breach response plan periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Completeness audit review	Reviews audit records for genuine, regular practice.

Method	What	Detail
DOCUMENT	Access control review	Reviews access control policy against actual staff access levels.
DOCUMENT	Breach response plan check	Reviews the plan for specificity and actionable steps.

SUPERVISOR TIPS

- **Ask for actual audit records, not a description of intended process.** — Dated findings are the only real evidence.
- **Check physical record access, not only electronic systems.** — Security attention often skews toward digital systems while physical files remain loosely controlled.

EVIDENCE BASE

[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.

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7.5 Incidents Are Actually Reported

NON-NEGOTIABLE

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

In plain terms: Staff actually report incidents — near-misses as well as harm — and the clinic can show it from the number and pattern of reports, not just the existence of a form.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A clinic that reports few incidents is not a safe clinic; it is a clinic where staff have stopped reporting. Incident reports are the raw material of learning: the near-miss today is the death next month if the cause is not found. Staff stop reporting when reports go nowhere, when they are blamed, when the form takes 20 minutes, or when nothing ever changes. The measure of a working system is volume and pattern: reports rising as trust builds, near-misses outnumbering harm events, every treatment area reporting. A form on the intranet with three reports a month is not a system.

WHAT GOOD LOOKS LIKE

- Reporting volume reflects genuine, ongoing use.
- Staff describe genuine confidence in reporting without punitive consequence.
- The system is accessible at the point of work.

COMMON FAILURE MODES

- Reporting volume is minimal or has dropped sharply with no explanation.
- Staff describe fear of blame as a reason they hesitate to report.
- The system is difficult to access in practice.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic with an incident form that generated 40 reports a year.

BEFORE

The form was four pages and required the reporter's name and manager's signature. Reports went to the medical director and stayed there. Staff described a colleague who had reported a medication error and been disciplined. Ward nurses estimated they saw 'several' near-misses a week; none were reported.

ACTION

The form was reduced to one page with an anonymous option. A no-blame policy was written and signed by the Director. Reports went to a

quality officer who acknowledged each within 48 hours, with the reporter told what was done. Monthly treatment area feedback showed what was learned. Near-miss reporting was actively encouraged with a 'good catch' recognition.

AFTER

The Monitor reviewed the log: 340 reports in the year, 60% near-misses, every treatment area reporting, average acknowledgement time 1.5 days. Interviewed three nurses who had reported and received feedback. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count last year's incident reports. Divide by beds. Under 2 per bed per year means under-reporting.
2. Ask five nurses when they last saw a near-miss and whether they reported it.
3. Cut the form to one page and allow anonymous reports.
4. Acknowledge every report within 48 hours and tell the reporter what happened.

The most common mistake: Interpreting a low incident count as a safe clinic — it is almost always a silent one.

SELF-ASSESSMENT QUESTIONS

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

COMMON REASONS FOR A PARTIAL ANSWER

- **Reporting happens for minor incidents but staff hesitate to report their own errors.** — Psychological safety often varies by perceived personal exposure.
- **Senior staff report reliably; junior staff report far less.** — Hierarchy can create very different real experiences within the same clinic.
- **A non-punitive policy exists but staff recall a past incident where reporting led to consequences.**

IMPLEMENTATION PLAN

When	What
Week 1	Review reporting volume trends for concerning patterns.
Week 2	Interview a cross-section of staff, including junior staff, about reporting confidence.
Week 3	Address any specific past incident undermining psychological safety.
Ongoing	Track reporting volume, investigating any significant drop.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Reporting volume review	Reviews reporting volume and pattern over time for genuine use.
ASK	Psychological safety interview	Asks staff directly whether they feel safe reporting an incident, including one they caused.
OBSERVE	System accessibility check	Checks how accessible the reporting mechanism is at the actual point of work.

SUPERVISOR TIPS

- **Ask junior staff specifically, not only senior staff.** — Hierarchy can create very different real experiences.
- **Ask about reporting one's own error specifically.** — Self-reporting confidence is usually the harder, more revealing test.

EVIDENCE BASE

[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.

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7.6 Staff Scope of Practice Is Verified CORE

Every clinical staff member's actual duties are matched to their verified scope of practice and licence category, not assumed appropriate because they've been performing the role for some time. Each new clinical staff member completes structured orientation before independent practice, and every clinical staff member's performance and competency is formally evaluated on a defined schedule.

In plain terms: Every clinical staff member's actual duties match what their licence allows — checked, not assumed because they have been doing it for years.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The nurse who has been prescribing 'under the doctor's authority' for a decade, the health assistant who does injections, the receptionist who triages — each may be working outside their legal scope of practice, exposing the patient to unqualified care and the clinic to liability. Scope creep is gradual and invisible; nobody decided it, it just happened. The standard asks for a deliberate check: for each clinical role, what does the licence permit, what does the person actually do, and do they match? Where they do not, either the duty changes or the qualification is obtained.

WHAT GOOD LOOKS LIKE

- Duties are specifically matched against verified scope for every staff member.
- This comparison is repeated periodically, not only at hiring.
- A defined correction process exists and is used when a mismatch is found.

COMMON FAILURE MODES

- No specific comparison exists beyond assumed appropriateness.
- Comparison happens only once, at hiring.
- No process exists to correct an identified mismatch.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic with two doctors, four nurses, two health assistants, and three receptionists.

BEFORE

A health assistant with no clinical qualification was giving vaccinations and taking blood. A nurse was issuing repeat prescriptions in the doctor's name. Receptionists were deciding which patients were 'urgent.' None of this had been decided; it had accumulated. Nobody had compared duties to licences.

ACTION

The practice manager listed every clinical task and who performed it, then checked each against the national scope of practice for that role. Three mismatches were found. The health assistant was moved off clinical tasks pending training; the nurse's prescribing was stopped and a proper delegated-prescribing arrangement set up; a triage protocol with nurse oversight replaced receptionist judgment. The review was scheduled annually.

AFTER

The Monitor reviewed the task-to-scope matrix, the corrected assignments, and the annual review date. Interviewed the health assistant who confirmed her current duties. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every clinical task done in the clinic and who does it.
2. For each role, find the national scope of practice.
3. Compare. Note every mismatch.
4. Fix each: change the duty or obtain the qualification.

The most common mistake: Assuming that because someone has always done a task, they are permitted to.

SELF-ASSESSMENT QUESTIONS

1. Is each staff member's actual duties matched against their verified licence category and scope? — *A specific comparison, not an assumption that current duties are appropriate.*

Evidence: Scope of practice review record

2. Is this comparison repeated periodically, not only done once at hiring? — *Duties can expand gradually over time without a formal decision ever being made.*

Evidence: Periodic review schedule

3. Is there a defined process if a mismatch is found? — *Identifying a mismatch without correcting it provides no real protection.*

Evidence: Correction process record

4. Does every new clinical staff member complete structured orientation before practising independently? — *A real, structured orientation programme, not informal shadowing alone.*

Evidence: Orientation completion record

5. Is every clinical staff member's performance and competency formally evaluated on a defined schedule, documented and shared with them? — *A genuine, periodic, documented evaluation, distinct from scope verification alone.*

Evidence: Performance evaluation record

COMMON REASONS FOR A PARTIAL ANSWER

- **Comparison happens for physicians but less consistently for support clinical staff.** — Attention often concentrates on the most visible role.
- **A mismatch was identified once but never actually corrected.** — Identification without correction leaves the underlying risk in place.

- Duties have gradually expanded informally without anyone reviewing scope.

IMPLEMENTATION PLAN

When	What
Week 1	Review current duties against verified scope for all clinical staff.
Week 2	Correct any mismatch found.
Week 3	Establish a periodic review schedule.
Ongoing	Repeat scope reviews on the defined schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Scope comparison review	Reviews evidence that actual duties are compared against verified scope.
DOCUMENT	Periodic review schedule check	Checks whether this comparison is repeated periodically.
ASK	Correction process interview	Asks what happens if a mismatch between duties and scope is found.

SUPERVISOR TIPS

- **Ask a staff member to describe their actual daily duties in detail.** — A detailed description can reveal drift a job title alone wouldn't show.
- **Check non-physician clinical staff specifically.** — Scope drift often goes unnoticed longest in less closely supervised roles.

EVIDENCE BASE

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

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7.7 Leadership Reviews Overall Performance at Planned Intervals

NON-NEGOTIABLE

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

In plain terms: Leadership sits down at a set interval — quarterly at least — to look at quality and safety trends across the whole clinic, not just the last incident.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

Reacting to incidents is necessary but insufficient. A clinic that only reviews quality when something goes wrong never sees the pattern: the referrals that are slowly taking longer, the complaints that cluster around one clinician, the infection rate that has crept up. A planned review — quarterly, with data — looks at trends: incidents, complaints, referral times, audit results, patient feedback, staff turnover. It asks: what is changing, and what should we do about it? This is the difference between managing a clinic and firefighting in one.

WHAT GOOD LOOKS LIKE

- Reviews happen at a genuine, defined, regular interval.
- Reviews cover trends and patterns across time.
- Reviews lead to documented decisions or actions.

COMMON FAILURE MODES

- No planned review exists beyond reacting to individual incidents.
- Reviews, if they happen, only list individual events without trend analysis.
- Reviews produce discussion but no documented follow-through.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic where quality was discussed only when a problem arose.

BEFORE	No scheduled review existed. Incidents were discussed when they happened. Complaints, audit results, and referral data were not collected in any form that could be reviewed. The clinical lead could not say whether the clinic was getting safer or less safe.
ACTION	A quarterly quality review was scheduled: a one-page dashboard of incidents, complaints, referral confirmation rate, record audit score, patient feedback score, and staff turnover. Each item has a trend arrow. The review produces two or three actions with owners. Minutes are kept.
AFTER	The Monitor reviewed three quarterly dashboards and minutes with actions closed. The dashboard showed complaints trending down and referral confirmation trending up. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pick six numbers that describe your clinic's quality: incidents, complaints, referral confirmations, audit score, feedback score, turnover.
2. Put them on one page with last quarter's figure beside this quarter's.
3. Schedule a quarterly meeting to review it.
4. Produce two actions from each meeting.

The most common mistake: Reviewing individual incidents thoroughly while never looking at the trend across all of them.

SELF-ASSESSMENT QUESTIONS

1. Does leadership review overall quality and safety performance at a defined, regular interval? — *A specific, planned interval, not only*

when something goes wrong.

Evidence: Management review schedule and minutes

2. Does the review cover trends and patterns, not only a list of individual incidents? — *Trend analysis reveals patterns a single-incident view misses entirely.*

Evidence: Trend analysis documentation

3. Does the review lead to documented decisions or actions, not just discussion? — *Review without resulting action provides limited real value.*

Evidence: Review outcome and action record

COMMON REASONS FOR A PARTIAL ANSWER

- **A review happens but only when leadership happens to have time, not on a fixed schedule.** — An irregular pattern risks the review being deprioritised indefinitely during busy periods.
- **Trends are informally noticed but never formally analysed or documented.** — Undocumented pattern recognition is hard to distinguish from coincidence.
- **Decisions are made during review but not tracked to completion afterward.**

IMPLEMENTATION PLAN

When	What
Week 1	Establish a specific, regular interval for a genuine performance review.
Week 2	Build a simple trend-analysis method covering incidents, complaints, and quality data together.
Week 3	Define how review decisions will be tracked to completion.
Ongoing	Hold the review on schedule and track action completion.
	For Micro (solo) Block a specific, recurring date on your own calendar — quarterly is reasonable — and use that time to read back through the last quarter's incidents, complaints, and near-misses as a reviewer would, not as you experienced them in the moment.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Review schedule and minutes review	Reviews evidence of a genuine, planned-interval management review, not only reactive incident discussion.
DOCUMENT	Trend coverage check	Checks whether reviews cover trends and patterns, not only individual events.
ASK	Outcome interview	Asks leadership for a specific example of a decision or action resulting from a review.

SUPERVISOR TIPS

- **Ask for the actual review schedule and minutes, not a description of intended practice.** — Dated records are the only real evidence of a consistent, planned process.
- **Ask for a specific example of a decision that came from a review, not an incident.** — This distinguishes genuine systematic review from incident-reactive management alone.

EVIDENCE BASE

[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.

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7.8 Quality Objectives Are Set, Specific, and Tracked

CORE

The clinic sets specific, measurable quality objectives for the coming period, and tracks progress against them — not a general aspiration to "provide good care" with no way to know if it's actually happening.

In plain terms: The clinic has written, measurable quality goals for the year — 'reduce missed referrals to under 5%' — and tracks whether it is hitting them.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

'Provide excellent care' is an aspiration. 'Reduce time-to-result-communication to under 48 hours by December' is an objective. The difference is that the second can be measured, and therefore managed. Quality objectives force the clinic to decide what matters most this year, put a number on it, and check progress. Three to five objectives are enough; more dilutes attention. Each needs a baseline, a target, a date, and an owner. At year end, the clinic knows what it achieved — and what it did not.

WHAT GOOD LOOKS LIKE

- Objectives are specific and genuinely measurable.
- Progress is actively tracked, not assumed.
- Relevant staff know the current objectives.

COMMON FAILURE MODES

- Objectives, if stated, are general aspirations with no measurable target.
- No tracking exists beyond a general sense of how things are going.
- Staff are unaware any specific objectives exist.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic with a mission statement and no objectives.

BEFORE

The clinic's stated goal was 'quality patient-centred care.' Nobody could say what that meant in numbers. When asked what had improved in the last year, the answer was 'we're always improving.' No baseline data existed for anything.

ACTION

At the quarterly review (7.7), the leadership set three objectives for the year: referral confirmation rate from 65% to 90%; abnormal result communication within 24 hours from unknown to

95%; hand hygiene compliance from 40% to 75%. Each had an owner and a monthly measure. Progress went on the dashboard.

AFTER

The Monitor reviewed the objectives, baselines, monthly tracking, and the year-end review: two of three achieved, the third at 68% with a revised plan. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Write down three things you would most like to improve this year.
2. For each, measure where you are now — that is the baseline.
3. Set a target number and a date.
4. Assign an owner and check monthly.

The most common mistake: Setting objectives without baselines — you cannot know you improved if you don't know where you started.

SELF-ASSESSMENT QUESTIONS

1. Are there specific, measurable quality objectives set for the coming period? — *A specific, numeric or otherwise measurable target, not a general aspiration.*

Evidence: Quality objectives document

2. Is progress against these objectives actually tracked? — *Tracked progress, not an assumption things are improving.*

Evidence: Progress tracking record

3. Are objectives communicated to relevant staff, not held only by leadership? — *Staff who don't know the objective can't meaningfully contribute to it.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Objectives are set but not revisited until the following year.** — Infrequent revisiting limits the ability to course-correct during the period.
- **Objectives are measurable but tracking happens informally without documentation.** — Undocumented tracking is hard to

distinguish from not tracking at all.

- **Leadership knows the objectives but they were never communicated to front-line staff.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current quality objectives, if any, for genuine specificity and measurability.
Week 2	Set or refine specific, measurable objectives for the coming period.
Week 3	Communicate objectives to relevant staff and establish a tracking method.
Ongoing	Track progress and revisit objectives at defined intervals.
	For Micro (solo) Write one or two specific, measurable objectives for the coming period, even though you're the only person who will track them — for example, a specific target for test-result turnaround time or patient complaint response time.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Objectives specificity review	Reviews whether objectives are genuinely specific and measurable, not general aspirations.
DOCUMENT	Progress tracking review	Reviews evidence of actual tracked progress against objectives.
ASK	Staff awareness interview	Asks relevant staff whether they know the clinic's current quality objectives.

SUPERVISOR TIPS

- **Ask for the actual objectives, with numbers or specific targets, not a general statement.** — Specificity is what distinguishes a real objective from an aspiration.
- **Ask a front-line staff member if they know the current objective.** — This reveals whether objectives genuinely reach beyond leadership.

EVIDENCE BASE

[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.

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7.9 **A Continual Improvement Process Exists, Not Only Reaction to Individual Incidents** CORE

The clinic has a defined process for identifying and acting on improvement opportunities generally, separate from and in addition to responding to specific incidents as they occur.

In plain terms: The clinic looks for ways to improve on its own initiative — audits, patient feedback, staff ideas — not only in response to something going wrong.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Incident response fixes what broke. Continual improvement finds what could be better before it breaks. The mechanisms are simple: a regular audit cycle (records, hand hygiene, prescribing), a patient feedback loop, a way for staff to suggest changes, and a routine of picking one thing to improve each quarter. The clinic that does this gets better steadily; the clinic that only responds to incidents stays the same between incidents. The standard asks for evidence of a process — not just good intentions — and of at least one improvement that did not originate from an incident.

WHAT GOOD LOOKS LIKE

- A defined, proactive improvement process exists, distinct from incident response.

COMMON FAILURE MODES

- No improvement happens outside of reacting to specific incidents.

- A real, recent example of proactive improvement can be shown.
- Staff know a specific channel for suggesting improvements.

- No recent example of proactive improvement exists.
- Staff have no known way to suggest an improvement idea.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic that responded well to incidents but had no improvement programme.

BEFORE

Every improvement in the clinic's history had followed an incident or a complaint. No audits were done proactively. Staff suggestions were made verbally and forgotten. The clinic was not getting worse — but it was not getting better either.

ACTION

A simple improvement cycle was set up: an annual audit calendar (one topic per month); a staff suggestion form reviewed at team meetings; one improvement project per quarter chosen from audit findings, feedback, or suggestions — with a before and after measure. The first project, from a staff suggestion, reorganised the treatment room and cut preparation time per procedure by 30%.

AFTER

The Monitor reviewed the audit calendar, four completed audits, the suggestion log, and two completed improvement projects with before/after data. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Write an audit calendar: twelve topics, one per month.
2. Put a suggestion form where staff can reach it and review it at team meetings.
3. Pick one improvement project this quarter — measure before and after.

4. Track it on your dashboard.

The most common mistake: Confusing good incident response with continual improvement — the first is reactive; the second finds what the incidents haven't revealed yet.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined process for identifying improvement opportunities, separate from incident response? — *A proactive process, not only reaction to something having gone wrong.*
Evidence: Continual improvement process document
2. Have any improvements been made through this process recently, not only through incident-driven correction? — *A real, recent example distinguishes genuine practice from a policy on paper.*
Evidence: Recent improvement example
3. Are staff able to suggest improvement ideas through a known channel? — *Front-line staff often see improvement opportunities leadership doesn't.*
Evidence: Staff suggestion channel

COMMON REASONS FOR A PARTIAL ANSWER

- **A suggestion channel exists but has never actually been used.** — An unused channel may not be genuinely known or trusted by staff.
- **Improvement happens but is driven entirely by leadership, without staff input.** — Front-line perspective often surfaces different opportunities than leadership sees.
- **A process exists on paper but the clinic cannot point to a real recent example.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for any proactive, non-incident-driven improvement activity.
Week 2	Establish a specific staff suggestion channel if none exists.
Week 3	Define a process for evaluating and acting on improvement suggestions.

When	What
Ongoing	Track and document real examples of proactive improvement.
	For Micro (solo) Use patient feedback specifically as your improvement input channel — actively ask a few patients each month what could have gone better, and keep a simple, dated log of ideas this surfaces and what you actually changed as a result.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Improvement process review	Reviews the defined process for identifying improvement opportunities separate from incidents.
DOCUMENT	Recent example review	Reviews for a real, recent example of proactive, non-incident-driven improvement.
ASK	Staff suggestion channel interview	Asks staff whether they know how to suggest an improvement idea.

SUPERVISOR TIPS

- **Ask for a real, recent example that wasn't triggered by an incident.** — This is the clearest test of whether improvement is genuinely proactive.
- **Ask a front-line staff member how they'd suggest an improvement idea.** — A confident, specific answer reveals whether the channel is genuinely known.

EVIDENCE BASE

[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.

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7.10

Patient Feedback Has an Independent Channel, Not Just an Internal One

CORE

Patients and families have a genuine, independent channel to raise concerns, praise, and ideas — one that reaches a body outside the clinic’s own management, not only an internal suggestion box or feedback form the clinic itself reviews and answers.

In plain terms: Patients can tell someone who isn’t the clinic itself when something’s wrong, or right — not just fill in a form the clinic reads and files away.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

A patient who's unhappy with a clinic they still depend on for care rarely says so honestly on the clinic's own form. The polite answer goes in the box; the real story goes to a review site or social media instead, later and angrier, after the clinic has lost the chance to fix it quietly. An independent channel, reaching a body with no stake in the outcome, is structurally more likely to surface a real problem while it's still small. ASF's Patient Voice service provides exactly this: a QR code, a neutral intermediary, and, for clinics that want it, a real patient council that meets regularly and reviews what patients are actually saying.

WHAT GOOD LOOKS LIKE

- An independent channel exists, genuinely reaching a body outside the clinic’s own management.
- Concerns raised through it are genuinely acknowledged and answered, not left unaddressed.
- Patterns in what patients raise genuinely inform real

COMMON FAILURE MODES

- The only feedback channel is an internal form the clinic itself reviews and answers.
- An independent channel exists on paper but nothing reaches the clinic from it in practice.
- Feedback is collected but never closes the loop with the person who raised it.

WORKED EXAMPLE

IN PRACTICE

A 13-staff ambulatory clinic whose only feedback mechanism was a paper suggestion box at reception.

BEFORE

The suggestion box was checked irregularly. Patients who raised a real concern rarely heard back. A long wait-time pattern on Tuesdays went unreported for months because no one wanted to complain to the receptionist who'd see the complaint.

ACTION

A QR code was placed at reception and in each exam room, linking to ASF's Patient Voice channel. Feedback now goes directly to ASF, not through the clinic first. ASF acknowledges within two working days and closes every case in writing.

AFTER

In the first quarter, five patients used the channel; two flagged the same Tuesday wait-time issue, and the clinic adjusted scheduling within the month — instead of the pattern going unreported indefinitely. The Monitor reviewed the case log. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read the [Patient Voice](#) page to see the full mechanism.
2. Place the QR code at reception and in every exam room.
3. Tell staff the channel exists and that it doesn't come back through them first.
4. Check in three months whether anything has actually come through it.

The most common mistake: Treating an internal suggestion box the staff themselves check as equivalent to an independent channel.

SELF-ASSESSMENT QUESTIONS

1. Do patients have a channel that reaches a body genuinely independent of the clinic's own management? — *A real external channel, not an internal form the clinic reviews itself.*

Evidence: Feedback channel documentation

2. Are concerns raised through it genuinely acknowledged and answered, not left to sit? — *Real, timely responses, not silence after submission.*

Evidence: Case log or response record

3. Do patterns in what patients raise genuinely inform real changes at the clinic? — *Evidence of at least one real change traceable to patient feedback.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A feedback channel exists but patients aren't told it's independent of the clinic.** — If patients don't know it reaches someone other than the clinic, it won't be used honestly.
- **Feedback is collected but responses are inconsistent or slow.** — A channel that doesn't close the loop trains patients to stop using it.
- **The channel is new and hasn't yet generated evidence of a real change resulting from it.**

IMPLEMENTATION PLAN

When	What
Week 1	Set up the Patient Voice QR code and review how it works.
Week 2	Place it at reception and in every exam room.
Week 3	Tell staff it exists and that it bypasses them by design.
Ongoing	Review what comes through it and confirm at least one real change traceable to it each year.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Channel review	Confirms an independent channel exists and is visibly accessible to patients.

Method	What	Detail
DOCUMENT	Response record review	Reviews whether concerns raised are genuinely acknowledged and answered.
INTERVIEW	Patient awareness check	Asks patients directly whether they know the channel exists and that it's independent.

SUPERVISOR TIPS

- **Ask a patient, not staff, whether they know how to reach someone outside the clinic with a concern.** — This reveals whether the channel is genuinely known, not just technically present.
- **Ask to see one real case that came through the channel and what changed because of it.** — A specific, real example reveals genuine use, not a channel that exists only on paper.

EVIDENCE BASE

Independent, external feedback channels are structurally more likely to surface an honest concern than a channel reviewed by the same organisation being reported on — the same reasoning that underlies independent ombuds and patient-advocacy practice in healthcare systems worldwide.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Ambulatory Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 6 — Aftercare & Follow-up**

Standard 8 — Dental Practice →

Standard 8 — Dental Practice

5 criteria · 5 non-negotiable · 0 core · Version 3.0

CRITERIA IN THIS STANDARD

- 8.1 — Dental Instrument Sterilization Is Monitored, Not Just Performed
- 8.2 — Aerosol-Generating Procedures Have Real Ventilation and PPE Control
- 8.3 — Every Dental X-Ray Is Justified, Not Routine
- 8.4 — Extraction and Surgical Consent Covers Real, Procedure-Specific Risk
- 8.5 — Amalgam Waste Is Captured and Disposed of Correctly

8.1 Dental Instrument Sterilization Is Monitored, Not Just Performed

NON-NEGOTIABLE

Sterilization of reusable dental instruments is verified through mechanical, chemical, and biological monitoring together, on a defined schedule, with results documented — not assumed complete because the sterilizer cycle finished.

In plain terms: Dental instrument sterilisation is proven to work — mechanical, chemical, and biological indicators together, on a schedule, with records — not assumed because the autoclave cycle finished.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A dental autoclave can complete a cycle and fail to sterilise: the chamber did not reach temperature, the load was packed too tightly, the door seal leaked. The instruments come out looking exactly the same. Hepatitis B, hepatitis C, and HIV have all been transmitted through inadequately sterilised dental instruments. Three-level monitoring catches what the eye cannot: the printout (mechanical) shows the cycle ran; the indicator strip (chemical) shows heat reached the pack; the spore test (biological, weekly) proves that living organisms were killed. All three, recorded, is the standard. Any one alone is a guess.

WHAT GOOD LOOKS LIKE

- All three monitoring types are used together, consistently, for every cycle.
- Biological indicator testing happens at least weekly with proper controls.
- Any inadequate result triggers genuine reprocessing before instruments are used.

COMMON FAILURE MODES

- Only mechanical readings are checked, with no chemical or biological monitoring.
- Biological indicator testing happens rarely or inconsistently.
- An inadequate monitoring result was noted but instruments were used regardless.

WORKED EXAMPLE

IN PRACTICE

A three-chair dental practice with a benchtop autoclave.

BEFORE

The autoclave printed a cycle report that nobody read. No chemical indicators were used inside packs. No biological indicator had ever been run. A door seal had been leaking for weeks — the cycle 'completed' but the chamber never reached 134°C. Instruments from that period were used on approximately 200 patients.

ACTION

Every pack now carries a class 5 chemical indicator, checked before use. The cycle printout is filed daily and signed. A biological indicator is run every Monday with results logged; if it fails, the autoclave is taken out of service and all loads since the last pass are reprocessed. The door seal was replaced and a service contract established.

AFTER

The Monitor reviewed eight weeks of printouts, indicator logs, and biological test results (all pass). Opened three sterile packs: indicators had changed correctly. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Open a sterilised pack. Is there a chemical indicator inside that has changed colour?
2. Find your last biological (spore) test result. If none exists, order a kit today.
3. Start filing autoclave printouts daily with a signature.
4. Write the rule: a failed spore test stops the autoclave until resolved.

The most common mistake: Trusting the cycle-complete beep — the autoclave beeps whether or not it sterilised.

SELF-ASSESSMENT QUESTIONS

1. Is every sterilization cycle monitored using mechanical, chemical, and biological indicators together, not just one? — *All three layers together — a completed cycle alone doesn't confirm sterility was achieved.*

Evidence: Sterilization monitoring log

2. Is a biological indicator run at least weekly, per manufacturer and international guidance? — *Biological testing is the only method that directly confirms spore-killing capability.*

Evidence: Biological indicator test record

3. When a monitoring result is inadequate, are affected instrument packs reprocessed before any use on a patient? — *An inadequate*

result without reprocessing defeats the purpose of monitoring at all.

Evidence: Reprocessing record following a failed result

COMMON REASONS FOR A PARTIAL ANSWER

- **Mechanical and chemical monitoring happen consistently, but biological testing lapses during busy periods.** — Biological testing is the only method confirming actual sterilizing capability — the other two only confirm the cycle ran.
- **Monitoring happens but records aren't consistently dated or retained.** — Undocumented monitoring is difficult to distinguish from monitoring that didn't happen.
- **The practice has a clear process but staff performing monitoring were never formally trained on it.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current sterilization monitoring practice against all three required indicator types.
Week 2	Establish or correct a weekly biological indicator testing schedule.
Week 3	Train staff performing monitoring and define the reprocessing response to any inadequate result.
Ongoing	Maintain dated monitoring records and review for consistency.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Monitoring log review	Reviews the sterilization monitoring log for consistent use of all three monitoring types.
DOCUMENT	Biological indicator frequency check	Confirms biological indicator testing happens at least weekly with matching control records.
OBSERVE	Failed-result response check	Checks whether any past inadequate result led to genuine reprocessing before patient use.

SUPERVISOR TIPS

- **Ask for the actual dated monitoring log, not a description of the process.** — Dated records are the only real evidence of consistent practice.
- **Ask specifically about the last biological indicator result and what would happen if it failed.** — A confident, specific answer reveals genuine understanding versus a memorized policy line.

EVIDENCE BASE

[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.

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This course teaches practical implementation of this standard. Free to enroll. ASF certificate on completion.

8.2 Aerosol-Generating Procedures Have Real Ventilation and PPE Control

NON-NEGOTIABLE

Procedures that generate dental aerosols use a defined combination of high-volume evacuation, appropriate respiratory protection, and adequate room ventilation or recovery time between patients — not standard surgical masks alone.

In plain terms: Drilling, scaling and other aerosol-producing procedures use high-volume suction, proper masks, and room ventilation or a gap between patients — not just a paper mask and hope.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A dental handpiece produces a fine aerosol of saliva, blood and water that hangs in the air for up to 30 minutes. Everything in that aerosol — tuberculosis, influenza, coronaviruses, hepatitis — is inhaled by the dentist, the assistant, and the next patient. A surgical mask stops droplets, not aerosol. Control means three things together: high-volume evacuation held near the tooth to capture aerosol at source; an FFP2/N95 respirator for the operator during aerosol-generating procedures; and either mechanical ventilation that changes the room air rapidly or a defined settle time between patients. A clinic doing only one has not controlled the risk.

WHAT GOOD LOOKS LIKE

- High-volume evacuation is used consistently during every aerosol-generating procedure.
- Respiratory protection matched to aerosol risk is used, not a standard mask alone.
- A specific, followed room turnover interval exists between patients.

COMMON FAILURE MODES

- Evacuation is used inconsistently or only for select cases.
- Standard surgical masks are relied on for aerosol-generating procedures.
- No defined recovery time exists between patients in the same space.

WORKED EXAMPLE

IN PRACTICE

A two-chair dental practice with windowless surgeries and no mechanical ventilation.

BEFORE

The dentist used a surgical mask. High-volume suction was available but the assistant used the low-volume saliva ejector for convenience. Patients were seated back to back with no gap. The surgery had no air changes. Two staff had contracted respiratory infections in the previous winter.

ACTION

High-volume evacuation became mandatory for every aerosol procedure, held by the assistant within 2 cm of the working tooth. FFP2 respirators were fit-tested for all clinical staff and worn for

aerosol procedures. A HEPA air cleaner rated for the room volume was installed in each surgery. A 15-minute gap after aerosol procedures was scheduled until the air cleaner's performance was verified.

AFTER

The Monitor observed a scaling procedure with HVE, FFP2, and air cleaner running. Reviewed the fit-test records and the scheduling template with gaps. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch a drilling procedure — is high-volume suction held next to the tooth, or is the saliva ejector doing the work?
2. Check what mask the operator wears during aerosol procedures. A surgical mask is not enough.
3. Measure your surgery's air changes, or install a rated HEPA unit.
4. Schedule gaps after aerosol procedures until ventilation is proven.

The most common mistake: Using the low-volume saliva ejector because it is easier to hold — it captures almost no aerosol.

SELF-ASSESSMENT QUESTIONS

- 1.** Is high-volume evacuation used consistently during aerosol-generating procedures? — *Consistent use, not reserved for occasional cases.*

Evidence: N/A — tested directly

- 2.** Is respiratory protection appropriate to aerosol exposure used, not a standard surgical mask alone? — *A specific, higher level of protection matched to genuine aerosol risk.*

Evidence: PPE protocol document

- 3.** Is there a defined recovery time or ventilation standard between patients in the same treatment space? — *A specific, followed interval, not an assumption the air clears quickly enough.*

Evidence: Room turnover protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Evacuation is used for most procedures but skipped for quick, perceived-low-risk ones.** — Aerosol generation depends on the procedure type, not how quick it feels.
- **Respiratory protection is available but not consistently worn by all staff present.** — Protection that exists but isn't consistently used provides limited real protection.
- **A turnover interval exists but is shortened under scheduling pressure.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current aerosol procedure practice against evacuation, PPE, and turnover standards.
Week 2	Address any gaps in evacuation use or respiratory protection.
Week 3	Establish and communicate a specific room turnover interval.
Ongoing	Observe practice periodically, particularly during busy scheduling periods.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Aerosol procedure observation	Observes an aerosol-generating procedure for consistent evacuation and PPE use.
DOCUMENT	PPE protocol review	Reviews the protocol for appropriate respiratory protection specific to aerosol exposure.
DOCUMENT	Room turnover review	Reviews the defined recovery time or ventilation standard between patients.

SUPERVISOR TIPS

- **Observe during a genuinely busy period, not a quiet one.** — Protocol discipline is most likely to erode under real scheduling pressure.
- **Check whether the turnover interval is actually followed, not just written down.** — A written interval that's routinely shortened in

practice doesn't provide real protection.

EVIDENCE BASE

[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.

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8.3 Every Dental X-Ray Is Justified, Not Routine

NON-NEGOTIABLE

Every dental radiograph is individually justified by clinical need, not taken as a routine default, with dose kept as low as reasonably achievable and equipment subject to regular quality control.

In plain terms: Every dental X-ray has an individual clinical reason recorded — not taken automatically at every visit — with the lowest workable dose and a quality-controlled machine.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Routine bitewings every six months regardless of the patient's risk is unjustified radiation. Dental radiation is low per image but cumulative over a lifetime, and children are most sensitive. Justification means: this patient, this reason, this image — recorded. Optimisation means: rectangular collimation, fast sensors or film, the smallest field. Quality control means: the machine's output is checked annually and images are audited for diagnostic quality. A practice that X-rays every new patient 'to have a baseline' has not justified a single one of those exposures.

WHAT GOOD LOOKS LIKE

- Every radiograph has a specific, documented clinical justification.
- Prior imaging is checked before ordering new radiographs.
- Equipment undergoes regular, documented quality control.

COMMON FAILURE MODES

- Radiographs are taken as a routine part of every visit, without specific justification.
- No check of prior imaging happens before ordering a new exposure.
- Equipment quality control is irregular or undocumented.

WORKED EXAMPLE

IN PRACTICE

A four-chair dental practice with a policy of bitewings at every six-month recall.

BEFORE

All recall patients received bitewings regardless of caries risk. New patients received a full-mouth series. No justification was recorded. The X-ray unit had not been checked in five years. Image quality was variable; retakes were common and unrecorded.

ACTION

A radiography protocol based on national guidance was adopted: intervals set by caries risk (6 months high, 12–24 months low); no routine full-mouth series; every exposure recorded with its clinical justification. Rectangular collimation was fitted. The unit was serviced and dose-verified. Retakes are logged and audited quarterly; a retake rate above 5% triggers review.

AFTER

The Monitor reviewed 30 records: every radiograph had a recorded justification; intervals matched risk. Retake rate 3%. Dose verification certificate on file. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten recall patient records: was an X-ray taken, and does the record say why?
2. Adopt a caries-risk-based interval protocol from national guidance.
3. Fit rectangular collimation if you have not.
4. Start a retake log and get your unit dose-checked.

The most common mistake: Taking bitewings at every recall because it is routine — routine is the opposite of justified.

SELF-ASSESSMENT QUESTIONS

1. Is each radiograph justified by a specific clinical reason, documented, not taken as a routine default for every visit? — *A specific, recorded clinical reason for this patient, this visit.*

Evidence: Radiograph justification documentation

2. Is prior imaging reviewed before ordering a new radiograph, to avoid unnecessary repeat exposure? — *Checking existing images first, not defaulting to a new exposure.*

Evidence: N/A — tested directly

3. Is X-ray equipment subject to regular quality control and calibration? — *Verified equipment performance, not assumed from the image looking acceptable.*

Evidence: Equipment quality control record

COMMON REASONS FOR A PARTIAL ANSWER

- **Justification is documented for complex cases but defaults to routine for standard check-ups.** — Routine visits still require individual justification under the same principle.
- **Prior imaging exists but isn't consistently checked before a new order.** — An available record that isn't checked provides no real protection against unnecessary exposure.
- **Equipment quality control happened once at installation but hasn't been repeated.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent radiographs for documented, specific justification.

When	What
Week 2	Establish a routine check of prior imaging before ordering new radiographs.
Week 3	Schedule or verify regular equipment quality control.
Ongoing	Audit justification documentation periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Justification documentation review	Reviews a sample of patient records for documented, specific justification of each radiograph.
ASK	Prior imaging review interview	Asks staff whether prior imaging is checked before ordering a new radiograph.
DOCUMENT	Equipment quality control review	Reviews quality control and calibration records for X-ray equipment.

SUPERVISOR TIPS

- **Ask for the specific clinical reason behind a recent radiograph, not a general policy statement.** — A specific, patient-level reason is the real evidence of individual justification.
- **Ask when equipment quality control was last performed, with a date.** — A vague answer suggests this isn't a genuinely maintained, ongoing practice.

EVIDENCE BASE

[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.

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8.4

Extraction and Surgical Consent Covers Real, Procedure-Specific Risk

NON-NEGOTIABLE

Consent for extraction or other invasive dental procedures includes a genuine conversation about procedure-specific risks — infection, prolonged bleeding, nerve involvement where relevant — not a generic consent form covering "dental treatment" broadly.

In plain terms: Before an extraction or dental surgery, the patient hears about the real risks of that procedure — infection, bleeding, nerve damage for lower wisdom teeth — and can repeat them, not just sign a generic form.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A lower third molar extraction carries a real risk of permanent lip and tongue numbness. An extraction in a patient on anticoagulants carries a real risk of prolonged bleeding. A patient who signs a form that says 'I consent to dental treatment' has consented to nothing specific and will feel deceived when the numbness does not resolve. Specific consent means: this procedure, its main risks, the alternatives, in language the patient understands, with time to ask questions, and a teach-back to confirm understanding. The signature comes last.

WHAT GOOD LOOKS LIKE

- Consent specifically names the procedure and its real, relevant risks.
- Patients can explain back the specific procedure and its main risks.
- Procedure-specific risks like nerve involvement are

COMMON FAILURE MODES

- Consent is a generic form covering "dental treatment" broadly.
- Patients cannot describe what their specific procedure involves.
- Relevant specific risks are never named directly.

directly discussed where relevant.

WORKED EXAMPLE

IN PRACTICE

A three-chair dental practice using a single general consent form for all procedures.

BEFORE

The consent form said 'I consent to the dental treatment discussed.' It was signed at reception before the patient saw the dentist. A patient who developed permanent lingual nerve damage after a lower wisdom tooth extraction stated she had never been told this was possible. The dentist believed he had 'mentioned it.'

ACTION

Procedure-specific consent sheets were written for the six most common surgical procedures, each listing the three to five main risks in plain language and the alternatives. Consent is taken by the treating dentist after examination, with the sheet explained, questions invited, and a teach-back question ('What is the main risk we discussed?'). The patient signs the specific sheet and keeps a copy.

AFTER

The Monitor reviewed 20 surgical records: each had a procedure-specific consent with teach-back noted. Interviewed two post-operative patients who could name the main risk. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your current consent form. Does it name a single specific risk?
2. Write a one-page sheet for each of your five most common surgical procedures.
3. Move consent from reception to the dentist's chair.
4. Add a teach-back line to every consent.

The most common mistake: Getting the form signed at reception before the patient has been examined — that is not consent to anything.

SELF-ASSESSMENT QUESTIONS

1. Does consent for an invasive procedure specifically name that procedure's real risks, not a generic "dental treatment" consent? —

Named, specific risks for this specific procedure.

Evidence: Procedure-specific consent record

2. Can the patient explain back what the specific procedure involves and its main risks? — *Tests genuine understanding, not just a signature.*

Evidence: N/A — tested directly

3. Where nerve involvement or other procedure-specific risk is relevant, is it specifically discussed? — *Named directly, not folded into a general risk statement.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Consent is procedure-specific for major surgical cases but generic for routine extractions.** — Even a routine extraction carries real, procedure-specific risk worth naming directly.
- **Risks are named on the form but not genuinely discussed in conversation.** — A form listing risks isn't the same as a patient understanding them.
- **Consent happens well before the procedure but isn't reconfirmed if circumstances change.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current consent documentation for genuine procedure specificity.
Week 2	Build procedure-specific consent content for common invasive procedures.
Week 3	Train staff to verify patient understanding, not just obtain a signature.
Ongoing	Spot-check patient understanding after consent conversations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Consent specificity review	Reviews consent records for procedure-specific content, not generic treatment consent.
ASK	Patient understanding check	Asks a patient to explain back what their specific procedure involves and its main risks.
OBSERVE	Consent conversation observation	Observes an actual consent conversation for genuine, procedure-specific discussion.

SUPERVISOR TIPS

- **Ask the patient, not the clinician, to describe the procedure and its risks.** — This tests actual understanding, not staff confidence in their own explanation.
- **Compare consent content across a routine extraction and a more complex surgical case.** — Genuinely different content reveals real specificity; near-identical text reveals a generic form.

EVIDENCE BASE

[16, 47] World Health Organization. WHO guidelines for safe surgery 2009: safe surgery saves lives. Geneva: WHO; 2009 — establishes genuine, procedure-specific informed consent as a precondition of safe invasive care, not an administrative formality covering treatment broadly.

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8.5 Amalgam Waste Is Captured and Disposed of Correctly

NON-NEGOTIABLE

Where dental amalgam is used, a compliant amalgam separator captures waste before it enters the wastewater stream, and all amalgam waste is collected and forwarded

to a licensed recycler, not discharged or discarded as general waste.

In plain terms: If you use amalgam, a working separator catches it before it goes down the drain, and the collected waste goes to a licensed recycler — never to general waste or the sewer.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Dental amalgam is roughly 50% mercury. Without a separator, every filling removed sends mercury into the wastewater, where it enters rivers, accumulates in fish, and returns to people. The Minamata Convention requires separators in most jurisdictions. A separator that is installed but never emptied or serviced stops working. The collected waste — including old fillings, excess amalgam, and empty capsules — must be stored in a sealed, labelled container and collected by a licensed hazardous waste contractor with a certificate. Amalgam in the sharps bin or the general waste is a regulatory breach and an environmental harm.

WHAT GOOD LOOKS LIKE

- A compliant, functioning amalgam separator is installed wherever needed.
- All categories of amalgam waste are collected and sent to a licensed recycler.
- Separator maintenance follows the manufacturer's schedule, with records kept.

COMMON FAILURE MODES

- No amalgam separator is installed, or it is present but not functioning.
- Amalgam waste, or some categories of it, are discarded as general waste.
- Separator maintenance is irregular or undocumented.

WORKED EXAMPLE

IN PRACTICE

A two-chair dental practice removing 10–15 amalgam fillings a week.

BEFORE	No separator was installed. Amalgam waste and empty capsules went in the sharps bin. The practice was unaware of the legal requirement. Chairside traps were rinsed into the sink.
ACTION	An ISO 11143-certified amalgam separator was installed on the main drain line, with a service contract for annual maintenance and cartridge replacement. A sealed, labelled amalgam waste container was placed in each surgery for excess amalgam, extracted teeth with amalgam, and capsules. A licensed contractor collects quarterly and issues a consignment note. The practice manager keeps the certificates.
AFTER	The Monitor inspected the separator with its service label, the labelled waste containers, and the last two contractor certificates. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether you have an amalgam separator on your drain.
If not, that is a legal gap.
2. Look in your sharps bin — is there amalgam in it?
3. Buy labelled amalgam waste containers for each surgery.
4. Contract a licensed hazardous waste collector and file every certificate.

The most common mistake: Putting amalgam waste in the sharps bin — it is hazardous waste with a different disposal route.

SELF-ASSESSMENT QUESTIONS

1. Is a compliant amalgam separator installed and functioning wherever amalgam is used or removed? — *Installed and genuinely functioning, not present but bypassed or unmaintained.*

Evidence: Amalgam separator installation and maintenance record

2. Is all amalgam waste — capsules, chairside traps, extracted teeth with amalgam — collected and forwarded to a licensed recycler? — *All amalgam waste categories, not only the most visible one.*

Evidence: Licensed recycler collection record

3. Is the amalgam separator maintained and replaced on the manufacturer's recommended schedule? — *A separator that isn't maintained loses its capture effectiveness over time.*

Evidence: Separator maintenance schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **A separator is installed but hasn't been serviced on schedule.**
— Capture effectiveness declines as a separator reaches its capacity without replacement.
- **Amalgam capsules are properly collected but extracted teeth with amalgam restorations are not.** — All amalgam-containing waste categories carry the same real environmental concern.
- **Collection happens but the recycler used isn't verified as licensed for this purpose.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm amalgam separator installation and current functioning status.
Week 2	Verify the recycler used is licensed and confirm collection covers all amalgam waste categories.
Week 3	Establish or correct a separator maintenance schedule.
Ongoing	Maintain dated records of separator maintenance and recycler collection.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Separator installation check	Physically confirms a compliant amalgam separator is installed and functioning.
DOCUMENT	Recycler collection record review	Reviews records confirming amalgam waste is forwarded to a licensed recycler.
DOCUMENT	Separator maintenance review	Reviews maintenance and replacement records against manufacturer schedule.

SUPERVISOR TIPS

- **Ask to see the amalgam separator directly, not just documentation of its purchase.** — A separator that exists on paper but isn't installed or functioning provides no real protection.
- **Ask specifically about extracted teeth with amalgam restorations.** — This category of amalgam waste is the most commonly overlooked in practice.

EVIDENCE BASE

[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.

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