

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

ASF STANDARDS · AMBULATORY CLINIC · STANDARD 14

Standard 14 — Cardiology & Cardiac Catheterization

3 criteria · 3 non-negotiable · 0 core · Version 3.0

CRITERIA IN THIS STANDARD

14.1 — Contrast Media Reaction Response Is Rehearsed, Not Theoretical

14.2 — Vascular Access Site Complications Are Actively Monitored

14.3 — Radiation Exposure to Patients and Staff Is Tracked and Limited

14.1 Contrast Media Reaction Response Is Rehearsed, Not Theoretical

NON-NEGOTIABLE

Staff are trained and drilled — not only briefed — on recognising and managing contrast media hypersensitivity reactions, with a risk-based premedication and management approach for patients with prior reaction history, and emergency treatment genuinely available at the point of contrast administration.

In plain terms: Staff who give contrast for cardiac procedures have rehearsed — not just read about — what to do for a contrast reaction, and know which patients need pre-medication.

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

WHY THIS MATTERS

Iodinated contrast causes anaphylactoid reactions in about 1 in 1,000 patients; severe reactions in 1 in 10,000. In a cath lab doing 1,000 procedures a year, that is one severe reaction annually — rare enough to be forgotten, frequent enough to happen. Patients with prior reactions, asthma, or atopy are at higher risk and benefit from steroid and antihistamine pre-medication. The response — stop contrast, adrenaline for anaphylaxis, airway support — must be reflexive. A lab that has briefed staff but never drilled will fumble the first real case.

WHAT GOOD LOOKS LIKE

- Staff have genuinely rehearsed the response, with dated drill records.
- The facility's protocol reflects current, evidence-based guidance.
- Emergency treatment is immediately available at the point of administration.

COMMON FAILURE MODES

- Only written protocol review has occurred, with no actual drill.
- The protocol reflects outdated premedication assumptions.
- Emergency treatment requires retrieval from another location.

WORKED EXAMPLE

IN PRACTICE

A cardiac catheterisation suite doing 800 procedures a year.

BEFORE

Staff had received a lecture on contrast reactions. No pre-medication protocol existed; prior reactions were noted but not acted on. Adrenaline was in the crash cart in the corridor. No drill had been run. A patient with a documented prior mild reaction received contrast without pre-medication and developed bronchospasm.

ACTION

A contrast reaction protocol was written: pre-procedure screening for prior reactions, asthma, and atopy; risk-based pre-medication (prednisolone and antihistamine) for high-risk patients; adrenaline and airway kit in the lab, not

the corridor; a laminated response algorithm on the wall. Quarterly simulation drills with debrief. All staff competency-assessed annually.

AFTER

The Monitor found the kit in the lab, reviewed the screening form in 20 records with pre-medication given where indicated, and reviewed three drill records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Where is adrenaline relative to the cath table? Time the walk.
2. Add a contrast reaction screen to pre-procedure assessment.
3. Write a pre-medication protocol for high-risk patients.
4. Run a drill this quarter.

The most common mistake: Noting a prior contrast reaction in the history and proceeding without pre-medication anyway.

SELF-ASSESSMENT QUESTIONS

1. Have staff actually rehearsed a contrast reaction response, not only reviewed a written protocol? — *A genuine drill, not a policy document read once.*

Evidence: Drill record, date and participants

2. Does the facility's approach to prior-reaction patients reflect current, evidence-based guidance, not outdated assumptions? — *Current practice, specifically checked against recent guidance updates.*

Evidence: Premedication and management protocol document

3. Is emergency treatment for anaphylaxis genuinely available at the point of contrast administration, not in a separate location? — *Immediately at hand, not requiring retrieval during an emergency.*

Evidence: Emergency treatment stock and location record

COMMON REASONS FOR A PARTIAL ANSWER

- **A drill was conducted once but hasn't been repeated since.** — Rehearsed response capability fades over time without periodic repetition.
- **The protocol was updated for severe reaction cases but not for mild prior-reaction management.** — Guidance has meaningfully

changed for mild reaction management specifically, not only severe cases.

- **Emergency treatment is nearby but not genuinely at every point where contrast is administered.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current protocol against the most recent contrast hypersensitivity guidance.
Week 2	Conduct an actual reaction response drill with all relevant staff.
Week 3	Verify emergency treatment is genuinely accessible at every point of contrast administration.
Ongoing	Repeat drills periodically and review protocol currency as guidance evolves.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Drill record review	Reviews records of actual rehearsed contrast reaction response drills.
DOCUMENT	Protocol currency review	Reviews the facility's premedication and management protocol against current guidance.
OBSERVE	Emergency treatment location check	Confirms emergency treatment is genuinely available at the point of contrast administration.

SUPERVISOR TIPS

- **Ask for the date of the last actual drill, not the date the protocol was written.** — A specific, recent drill date is the real evidence of rehearsed readiness.
- **Ask specifically about management of a patient with a prior mild reaction.** — This is exactly where guidance has changed most recently, and where outdated practice most commonly persists.

EVIDENCE BASE

[70] Established professional consensus guidance on the management and prevention of hypersensitivity reactions to radiocontrast media establishes risk-based, evidence-updated management of contrast

hypersensitivity, including current guidance on premedication versus agent substitution.

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14.2 Vascular Access Site Complications Are Actively Monitored

NON-NEGOTIABLE

Patients are monitored for vascular access site complications — bleeding, hematoma, pseudoaneurysm — on a defined schedule appropriate to the access site used, with staff specifically trained on the distinct complication patterns of the access site actually used for each patient.

In plain terms: After cardiac catheterisation, the puncture site is checked on a set schedule for bleeding, swelling, and pulsatile masses — by staff trained to recognise them.

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

WHY THIS MATTERS

Femoral access complications — retroperitoneal haemorrhage, pseudoaneurysm, AV fistula — can be fatal and present hours after the procedure, when the patient looks well. Radial access is safer but not risk-free. A defined monitoring schedule — site inspection, distal pulses, vital signs at 15 minutes for the first hour, then hourly — catches a bleed before it becomes a transfusion. Staff must know what a pseudoaneurysm feels like (pulsatile, with a bruit) and what retroperitoneal bleeding looks like (back pain, hypotension, no visible haematoma). 'Keep an eye on the groin' is not monitoring.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Monitoring is genuinely specific to the access site actually used.
- Staff are specifically trained on complications distinct to each access type used here.
- Monitoring follows a defined, documented schedule.

- A generic monitoring approach is applied regardless of access site.
- Training doesn't distinguish between access-site-specific complication patterns.
- Monitoring is informal or inconsistently documented.

WORKED EXAMPLE

IN PRACTICE

A cardiac day unit receiving patients after femoral and radial catheterisation.

BEFORE

Post-procedure monitoring was 'observations as usual' — every four hours. A patient developed a retroperitoneal bleed three hours after femoral access; the fall in blood pressure was attributed to 'vasovagal' until she collapsed. Nurses had no specific training on access site complications.

ACTION

An access-site monitoring protocol was written: site inspection, distal pulse, and vital signs every 15 minutes for one hour, every 30 minutes for the next two hours, then hourly until discharge; specific signs to escalate (expanding haematoma, pulsatile mass, back pain with hypotension, loss of distal pulse). All day unit nurses completed a half-day session with a simulated pseudoaneurysm and a haemorrhage scenario.

AFTER

The Monitor reviewed 20 post-procedure charts with monitoring at protocol intervals, training records for all nurses, and one escalation for an expanding haematoma managed correctly. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten post-catheterisation charts: how often was the site checked in the first hour?
2. Write a monitoring schedule by access type with escalation triggers.
3. Train nurses to recognise pseudoaneurysm and retroperitoneal bleeding.
4. Add site checks to the observation chart as a required field.

The most common mistake: Attributing post-catheterisation hypotension to a vasovagal reaction without excluding bleeding.

SELF-ASSESSMENT QUESTIONS

1. Is monitoring specific to the actual access site used for each patient, not a generic approach applied regardless? — *Site-specific monitoring, reflecting the genuinely different risk pattern of radial versus femoral access.*

Evidence: Access-site-specific monitoring protocol

2. Are staff specifically trained to recognise complications distinct to each access site type used at this facility? — *Specific training matched to the access types actually used, not general awareness.*

Evidence: Access-site complication training record

3. Is monitoring conducted on a defined schedule appropriate to the access site, with findings documented? — *A specific, followed schedule, not informal or inconsistent checking.*

Evidence: Monitoring schedule and documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Femoral access monitoring is thorough but radial-specific monitoring is less developed.** — Facilities transitioning toward radial access sometimes retain monitoring protocols built for femoral risk patterns.
- **Training covers major complications but not more subtle, access-specific presentation patterns.** — Early, subtle signs are exactly where access-specific knowledge matters most for catching a problem early.
- **Monitoring happens but documentation is inconsistent across shifts.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current monitoring practice for genuine access-site specificity.
Week 2	Update training to cover complication patterns specific to each access type used.
Week 3	Establish a defined, documented monitoring schedule for each access type.
Ongoing	Audit monitoring documentation consistency across shifts.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Monitoring protocol review	Reviews the monitoring protocol for genuine access-site specificity.
DOCUMENT	Training record review	Reviews training records for access-site-specific complication recognition.
OBSERVE	Monitoring practice observation	Observes actual post-procedure monitoring practice for schedule adherence.

SUPERVISOR TIPS

- **Ask staff to describe the specific complication signs for the access site used in a recent case.** — Specificity reveals whether training genuinely reflects access-site differences.
- **Check monitoring documentation across different shifts, not just one.** — Consistency across shifts reveals whether this is genuine, embedded practice.

EVIDENCE BASE

[71] Access-site-specific complication monitoring, reflecting genuinely different risk profiles and presentation patterns between radial and femoral vascular access, is established practice in interventional cardiology safety literature.

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14.3 Radiation Exposure to Patients and Staff Is Tracked and Limited

NON-NEGOTIABLE

Radiation dose to both patients and staff is tracked per procedure, using ALARA-consistent technique to minimise exposure, with cumulative staff exposure monitored against recognised occupational limits — not managed only by general awareness that radiation exposure matters.

In plain terms: Radiation dose to patients and staff is measured per procedure, kept as low as possible, and staff exposure is tracked against legal limits with personal dosimeters.

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

WHY THIS MATTERS

A cardiac catheterisation delivers 50–100 times the radiation of a chest X-ray; complex interventions deliver enough to cause skin injury. Staff standing at the table for years accumulate doses that cause cataracts, and — for the eye lens — exceed occupational limits faster than most realise. Tracking means recording dose-area product and fluoroscopy time per procedure, reviewing protocols against reference levels, and issuing personal dosimeters (body and eye) to all staff with monthly readings reviewed against limits. ALARA — as low as reasonably achievable — requires knowing what the dose is.

WHAT GOOD LOOKS LIKE

- Patient dose is tracked per procedure and genuinely reviewed.
- ALARA-consistent technique is genuinely applied in practice.
- Staff dosimetry is consistently worn and

COMMON FAILURE MODES

- Dose data, if collected, is never reviewed.
- ALARA principles are known but not consistently applied in actual technique.
- Dosimetry badges are issued but not consistently worn or reviewed.

reviewed against
occupational limits.

WORKED EXAMPLE

IN PRACTICE

A catheterisation lab with three operators and six nursing and technical staff.

BEFORE

Patient dose was recorded automatically by the machine but never reviewed. Staff wore body dosimeters that were read quarterly and filed without review. No eye dosimeters were used. Lead glasses were available but rarely worn. One operator had early cataracts at 45.

ACTION

A radiation safety lead was appointed. Patient dose per procedure is now reviewed monthly against national reference levels; protocols with high dose were adjusted (pulsed fluoroscopy, collimation, frame rate). Eye dosimeters were issued to all table staff. Monthly dosimeter readings are reviewed and any staff member approaching 30% of the annual limit is reviewed. Lead glasses and thyroid shields became mandatory at the table. Ceiling-suspended shields were installed.

AFTER

The Monitor reviewed six months of patient dose reports with protocol adjustments, dosimeter records for all staff with eye doses, and observed a procedure with full shielding in use. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull the last month's patient doses from your machine and compare to national reference levels.
2. Check whether every table staff member has a current dosimeter, including eye.
3. Review the last dosimeter readings — has anyone reviewed them?
4. Make lead glasses mandatory today.

The most common mistake: Wearing body dosimeters but not eye dosimeters — the lens is the organ most at risk in a cath lab.

SELF-ASSESSMENT QUESTIONS

1. Is patient radiation dose tracked per procedure, with the data reviewed, not just generated and filed? — *Genuine tracking and review, not data collected without ever being examined.*

Evidence: Patient dose tracking record

2. Are ALARA-consistent technique practices — collimation, appropriate frame rate, distance optimisation — genuinely applied, not just known about? — *Applied in actual practice, not simply familiar concepts.*

Evidence: N/A — tested directly

3. Is cumulative staff radiation exposure monitored against recognised occupational limits, with dosimetry genuinely worn and reviewed? — *Real, worn dosimetry with genuine review, not badges issued but not consistently used or checked.*

Evidence: Staff dosimetry and exposure tracking record

COMMON REASONS FOR A PARTIAL ANSWER

- **Patient dose is tracked but not reviewed for trends across the practice.** — Individual case tracking without trend review misses systemic patterns worth addressing.
- **ALARA technique is applied by senior staff but less consistently by newer team members.** — Consistent radiation safety practice needs to extend to everyone performing procedures, not only the most experienced.
- **Dosimetry is worn but exposure data isn't reviewed on a regular schedule.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current patient dose tracking and staff dosimetry practice.
Week 2	Establish or strengthen ALARA-consistent technique training for all staff.
Week 3	Establish a regular schedule for reviewing both patient dose trends and staff exposure data.

When	What
Ongoing	Review dose and exposure data on the established schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Patient dose tracking review	Reviews patient radiation dose records for consistency and genuine review.
OBSERVE	ALARA technique observation	Observes actual procedural technique for ALARA-consistent practice.
DOCUMENT	Staff dosimetry review	Reviews staff dosimetry records against recognised occupational exposure limits.

SUPERVISOR TIPS

- **Ask to see actual dose tracking data and staff dosimetry records, not a general assurance of radiation safety awareness.**
— Specific, dated records are the only real evidence of genuine tracking.
- **Observe actual procedural technique for specific ALARA practices — collimation, frame rate, distance.** — Direct observation reveals whether ALARA is genuinely applied, not just a familiar concept.

EVIDENCE BASE

[72] Established clinical expert consensus on cardiac catheterization laboratory standards establishes ALARA (as low as reasonably achievable) as the governing principle for radiation use in the catheterization laboratory, with defined occupational exposure limits for staff.

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← **Ambulatory Clinic Standards — all standards**

Self-assess against these

criteria →

← Standard 13 — Fertility & IVF

**Standard 15 —
Ophthalmology & Day
Surgery →**

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Standard 15 — Ophthalmology & Day Surgery

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

CRITERIA IN THIS STANDARD

- 15.1 — Endophthalmitis Prevention Protocol Is Followed Precisely, Not Approximately
- 15.2 — Surgical Consent Covers Realistic Outcome Expectations, Not Just Risk
- 15.3 — Post-Procedure Vision Is Checked Before Discharge, Not Assumed Stable

15.1 Endophthalmitis Prevention Protocol Is Followed Precisely, Not Approximately

NON-NEGOTIABLE

Cataract and other intraocular procedures follow a precise, evidence-based endophthalmitis prevention protocol — specific povidone-iodine antisepsis timing and intracameral antibiotic use — verified as actually followed to the letter, not approximated or applied loosely.

In plain terms: For every cataract and eye surgery, the infection prevention steps — povidone-iodine on the eye at the right time, intracameral antibiotic — are done exactly as the protocol states and checked.

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

WHY THIS MATTERS

Endophthalmitis — infection inside the eye after surgery — destroys vision in days. It occurs in about 1 in 1,000 cataract operations without prophylaxis and 1 in 5,000 with the ESCRS-recommended bundle: 5% povidone-iodine applied to the ocular surface and left for at least three minutes before incision, plus intracameral cefuroxime at the end of surgery. The difference between 'we use iodine' and 'we apply 5% iodine for a timed three minutes' is the difference between the two rates. Precision matters; the protocol must be written, timed, and audited.

WHAT GOOD LOOKS LIKE

- Antisepsis timing precisely follows the evidence-based protocol.
- Intracameral antibiotic is prepared correctly at the specific evidence-supported dose.
- Protocol adherence is periodically verified, not just assumed.

COMMON FAILURE MODES

- Antiseptic is used but timing isn't specifically controlled or verified.
- Intracameral antibiotic preparation carries meaningful risk of dilution error.
- No verification happens beyond the protocol existing on paper.

WORKED EXAMPLE

IN PRACTICE

An ophthalmology day surgery unit performing 1,500 cataract operations a year.

BEFORE

Povidone-iodine was applied 'before surgery' — by the scrub nurse, at variable concentration, with no timing. Intracameral antibiotic was used by two of four surgeons. The unit's endophthalmitis rate was unknown. Two cases had occurred in the previous year.

ACTION

The ESCRS protocol was adopted as unit policy: 5% povidone-iodine applied to the conjunctival sac and periocular skin, with a timer started and a minimum three-minute contact before draping, documented; intracameral cefuroxime 1 mg in 0.1 ml at the end of every case (or moxifloxacin for cephalosporin allergy). Both steps added to the

theatre checklist. Monthly audit of 30 cases.
Endophthalmitis surveillance with 6-week follow-up.

AFTER The Monitor observed two cases with timed iodine and intracameral antibiotic documented, reviewed three months of audits (compliance 98%), and surveillance showing zero endophthalmitis in 400 cases. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch a cataract case. Is iodine timed? What concentration? Is intracameral antibiotic given?
2. Adopt the ESCRS protocol verbatim.
3. Add both steps to the theatre checklist with a timer.
4. Start endophthalmitis surveillance.

The most common mistake: Applying iodine and proceeding immediately — the three-minute contact time is what kills the bacteria.

SELF-ASSESSMENT QUESTIONS

1. Is povidone-iodine antiseptics applied with the specific, evidence-based timing — not just used generally at some point before surgery? — *A specific timing protocol, not general antiseptic use approximated by feel.*

Evidence: Antisepsis protocol document

2. Is intracameral antibiotic prophylaxis used at the specific dose supported by evidence, prepared correctly to avoid dilution error? — *The specific, evidence-supported approach, prepared with genuine care against a known error risk.*

Evidence: Intracameral antibiotic protocol and preparation record

3. Is the actual protocol followed verified periodically, not assumed from the fact that a protocol exists? — *Genuine verification, not an assumption that a written protocol is automatically followed precisely.*

Evidence: Protocol adherence verification record

COMMON REASONS FOR A PARTIAL ANSWER

- **Antisepsis is used consistently but exact timing varies by individual surgeon's practice.** — The specific timing itself is part of what the evidence supports, not general antiseptic use alone.
- **Intracameral antibiotic is used but preparation isn't specifically double-checked for dilution accuracy.** — Dilution error is a specifically documented risk with this exact preparation.
- **The protocol is written precisely but hasn't been recently verified against actual practice.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current antisepsis and intracameral antibiotic practice against the specific evidence-based protocol.
Week 2	Standardise antisepsis timing and antibiotic preparation across all surgeons.
Week 3	Establish a periodic verification process for actual protocol adherence.
Ongoing	Re-verify adherence periodically, particularly with any change in surgical staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Antisepsis protocol review	Reviews the specific antisepsis timing protocol against evidence-based recommendations.
OBSERVE	Intracameral antibiotic preparation observation	Observes actual preparation of intracameral antibiotic for correct dose and dilution.
DOCUMENT	Protocol adherence verification review	Reviews evidence that the protocol is periodically verified as actually followed.

SUPERVISOR TIPS

- **Ask a specific surgeon to describe their exact antisepsis timing, not a general description.** — Specificity reveals whether the precise, evidence-based protocol is genuinely followed.

- **Observe intracameral antibiotic preparation directly if timing allows.** — Direct observation is the clearest evidence of correct, careful preparation against dilution error.

EVIDENCE BASE

[73] Barry P, Seal DV, Gettinby G, Lees F, Peterson M, Revie CW; ESCRS Endophthalmitis Study Group. ESCRS study of prophylaxis of postoperative endophthalmitis after cataract surgery: preliminary report of principal results from a European multicenter study. J Cataract Refract Surg. 2006;32(3):407-410 — a multicenter study of over 16,000 patients demonstrating a near five-fold reduction in endophthalmitis with intracameral antibiotic prophylaxis.

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15.2 Surgical Consent Covers Realistic Outcome Expectations, Not Just Risk CORE

Consent for cataract and refractive procedures includes a genuine, honest discussion of realistic outcome expectations — including the real possibility of needing glasses afterward, or less than perfect vision — not only a list of physical risks with success implicitly assumed.

In plain terms: Before cataract or laser eye surgery, the patient hears an honest account of what vision they can realistically expect — including that they may still need glasses — not just the risks.

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

WHY THIS MATTERS

Patients expect cataract surgery to give them perfect vision. Many will still need glasses for reading, some for distance, and some will have residual astigmatism or a lens that does not sit perfectly. Refractive surgery patients expect to throw away their glasses forever; some will need them again in a decade, some will have dry eye or night glare. A

patient whose expectations were realistic is satisfied with a good result; a patient who was promised perfection is angry with the same result. Consent must cover expected outcome, not just complications — and the patient's own visual goals must be documented against what is achievable.

WHAT GOOD LOOKS LIKE

- Consent genuinely discusses realistic visual outcome expectations.
- The possibility of still needing glasses or imperfect vision is explicitly, honestly discussed.
- Patients can explain back realistic expectations specific to their own case.

COMMON FAILURE MODES

- Consent lists physical risks only, with success implicitly assumed.
- Glasses or imperfect outcome possibility isn't discussed.
- Patients cannot describe realistic expectations for their own case.

WORKED EXAMPLE

IN PRACTICE

An ophthalmology unit with a high rate of dissatisfaction complaints after cataract surgery.

BEFORE

Consent listed complications. Outcome expectations were not discussed. Patients chose monofocal lenses without understanding they would need reading glasses. Fourteen complaints in a year were about 'still needing glasses' or 'not as good as promised.' Surgeons said patients 'don't listen.'

ACTION

A pre-operative expectation discussion was structured: the patient states their visual goals; the surgeon explains what the chosen lens will and will not achieve (distance vs near, the certainty of reading glasses with monofocal), the possibility of residual refractive error, and typical recovery. A one-page outcome expectation sheet is completed and signed. Lens options are explained with a decision aid.

AFTER

The Monitor reviewed 20 records with completed expectation sheets. Dissatisfaction complaints fell from 14 to 3 in the following year. Interviewed a post-operative patient who accurately described what she had been told to expect. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Review your last year's complaints — how many are about unmet expectations?
2. Write a one-page 'What to expect' sheet per procedure type.
3. Record the patient's visual goals and the surgeon's realistic response.
4. Use a lens decision aid.

The most common mistake: Discussing risks thoroughly and outcomes vaguely — the dissatisfied patient rarely had a complication; they had an expectation.

SELF-ASSESSMENT QUESTIONS

1. Does consent genuinely discuss realistic visual outcome expectations, not only physical risks? — *A real discussion of what vision will likely be like afterward, not just what could go wrong.*
Evidence: Outcome expectation discussion documentation
2. Is the real possibility of still needing glasses, or less than perfect vision, explicitly discussed? — *Honest, specific discussion, not an assumption of a perfect outcome.*
Evidence: N/A — tested directly
3. Can the patient explain back realistic expectations for their own specific case? — *Tests genuine understanding specific to this patient, not general awareness that outcomes vary.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Outcome discussion happens for complex cases but is abbreviated for routine cataract surgery.** — Even routine-seeming procedures benefit from genuinely realistic expectation-setting.
- **Glasses possibility is mentioned but not discussed in enough detail for genuine understanding.** — A passing mention isn't the same as a patient genuinely internalising a realistic expectation.

- Discussion happens well before surgery but isn't reconfirmed closer to the actual procedure date.

IMPLEMENTATION PLAN

When	What
Week 1	Review current consent practice for genuine outcome expectation discussion.
Week 2	Build specific, honest outcome discussion into the standard consent process.
Week 3	Train staff to verify patient understanding of realistic expectations, not just obtain a signature.
Ongoing	Spot-check patient understanding of expectations after consent conversations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Outcome discussion review	Reviews consent documentation for genuine outcome expectation discussion, not risk disclosure alone.
OBSERVE	Consent conversation observation	Observes an actual consent conversation for genuine discussion of realistic outcomes.
ASK	Patient understanding check	Asks a patient to describe realistic expectations for their own specific procedure.

SUPERVISOR TIPS

- **Ask the patient what they expect their vision to be like afterward.** — This tests actual understanding and expectation-setting, not just that risks were listed.
- **Check consent practice for routine cataract cases specifically, not only complex ones.** — Genuine expectation-setting matters even when the procedure feels routine.

EVIDENCE BASE

[74] Realistic, individualised discussion of expected visual outcomes, distinct from physical risk disclosure alone, is identified in ophthalmic surgery literature as a determinant of patient satisfaction independent of surgical success.

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

15.3 Post-Procedure Vision Is Checked Before Discharge, Not Assumed Stable

NON-NEGOTIABLE

Every patient undergoes a genuine post-procedure vision and eye check before discharge, with specific criteria for what triggers extended observation or same-day escalation — not discharged based on general appearance or the patient simply feeling ready to leave.

In plain terms: After eye surgery, every patient has their vision and eye checked before going home, with written criteria for who needs to stay longer or be seen urgently.

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

WHY THIS MATTERS

Raised intraocular pressure after cataract surgery peaks at 4–6 hours and can damage the optic nerve. A wound leak, a dislocated lens, an early sign of infection — each is detectable at a pre-discharge check and each is a disaster if the patient goes home unassessed. The check is short: visual acuity, pressure if indicated, slit lamp look at the wound and anterior chamber. The criteria are written: pressure above X, any wound leak, unexpected pain or vision loss → stay or urgent review. 'Discharge when comfortable' sends the raised pressure home to lose vision overnight.

WHAT GOOD LOOKS LIKE

- Every patient undergoes a genuine, specific pre-discharge assessment.

COMMON FAILURE MODES

- Discharge is based on general appearance or patient readiness alone.

- Specific, defined criteria exist for extended observation or escalation.
- The assessment is performed by someone specifically qualified for it.

- No specific criteria exist beyond general judgement about whether something seems wrong.
- The check, if performed, is done by whoever is available, not specifically qualified staff.

WORKED EXAMPLE

IN PRACTICE

An ophthalmology day unit discharging cataract patients 30 minutes after surgery.

BEFORE

Patients were discharged when they felt well, with drops and a leaflet. No post-operative examination was routine. A patient went home with a pressure of 45 mmHg, developed severe pain overnight, and lost partial vision. There were no discharge criteria.

ACTION

A pre-discharge check was made mandatory: visual acuity, IOP, and slit lamp examination by a doctor or trained nurse before discharge; written criteria — IOP >30 → treat and recheck; any wound leak → return to theatre or pressure patch and review; any unexpected finding → surgeon review before discharge. Discharge is signed against the criteria. A 24-hour phone number is given.

AFTER

The Monitor reviewed 25 discharge records with completed checks and criteria applied; two showed extended observation for raised pressure, treated and rechecked before discharge. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten discharge records: was the eye examined before discharge?
2. Write discharge criteria: acuity, pressure, wound, symptoms.

3. Require a signed check against the criteria before every discharge.
4. Issue a 24-hour number.

The most common mistake: Discharging when the patient feels fine — raised pressure is painless until it is too late.

SELF-ASSESSMENT QUESTIONS

1. Does every patient undergo a genuine, specific vision and eye check before discharge, not a general assessment of how they seem? — *A specific clinical check, not a general impression.*

Evidence: Pre-discharge assessment documentation

2. Are there specific, defined criteria for what would trigger extended observation or escalation? — *Specific, known criteria, not a vague sense that something seems off.*

Evidence: Extended observation criteria document

3. Is the check performed by someone specifically qualified to recognise early signs of complication? — *A qualified assessor, not whoever happens to be available at discharge time.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Assessment is thorough for complex procedures but abbreviated for routine cataract cases.** — Early complications can occur even after routine-seeming procedures.
- **Criteria for escalation exist but aren't consistently applied by all staff performing discharge checks.** — Written criteria only provide real protection when consistently applied by everyone using them.
- **The assessment happens but timing is rushed during busy periods.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current discharge practice for genuine, specific vision and eye assessment.
Week 2	Establish specific, defined criteria for extended observation or escalation.

When	What
Week 3	Ensure the assessment is consistently performed by specifically qualified staff.
Ongoing	Audit discharge assessment consistency, particularly during busy periods.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Pre-discharge assessment review	Reviews documentation for genuine, specific vision and eye assessment before discharge.
DOCUMENT	Escalation criteria review	Reviews the specific, defined criteria for extended observation or escalation.
OBSERVE	Assessor qualification check	Confirms the pre-discharge check is performed by someone specifically qualified to recognise complications.

SUPERVISOR TIPS

- **Ask what specifically would trigger extended observation, not a general description of the discharge process.** — Specific, known criteria reveal genuine readiness versus a general policy statement.
- **Observe an actual discharge assessment if timing allows.** — Direct observation reveals whether this is a genuine, specific check or a general impression.

EVIDENCE BASE

[75] Structured post-procedure ocular assessment prior to discharge, with defined criteria for extended observation, is established practice in ambulatory ophthalmic surgery to catch early complications while the patient remains on-site.

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**Self-assess against these
criteria →**

**← Standard 14 — Cardiology
& Cardiac Catheterization**

**Standard 16 — Diagnostic
Imaging →**

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ASF STANDARDS · AMBULATORY CLINIC · STANDARD 16

Standard 16 — Diagnostic Imaging

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

CRITERIA IN THIS STANDARD

16.1 — CT Radiation Dose Is Tracked and Benchmarked, Not Just Delivered

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

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

16.1 CT Radiation Dose Is Tracked and Benchmarked, Not Just Delivered

NON-NEGOTIABLE

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

In plain terms: CT radiation dose is recorded for every scan and regularly compared with national reference levels; protocols giving more dose than necessary are adjusted.

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

WHY THIS MATTERS

A CT abdomen delivers the equivalent of two years of background radiation. Dose varies four-fold between facilities for the same scan, mostly through protocol settings that nobody has reviewed since installation. Children are especially sensitive, and a single unnecessary high-dose CT measurably increases lifetime cancer risk. Diagnostic reference levels — published nationally or internationally — give a benchmark; a facility whose median dose exceeds the DRL for a given examination is delivering more radiation than most of its peers. Tracking, benchmarking, and adjusting is how a facility knows it is not among the worst.

WHAT GOOD LOOKS LIKE

- Dose is tracked consistently for every CT examination.
- Facility data is periodically compared against a recognised external benchmark.
- A real example exists of benchmarking leading to protocol review and adjustment.

COMMON FAILURE MODES

- Dose tracking is occasional or incomplete.
- No external benchmark comparison happens, only internal review if any.
- Benchmarking data, if collected, has never led to a protocol change.

WORKED EXAMPLE

IN PRACTICE

An imaging centre with one 64-slice CT scanner performing 4,000 scans a year.

BEFORE

Dose was recorded by the scanner but never extracted or reviewed. Protocols were the manufacturer's defaults from installation six years earlier. No paediatric protocols existed; children were scanned with adult settings. Nobody knew whether the centre's doses were high or low.

ACTION	A dose management process was set up: monthly extraction of CTDIvol and DLP for the ten most common examinations, median compared to national DRLs; protocols exceeding DRLs were reviewed with the manufacturer's applications specialist and adjusted (iterative reconstruction, automatic exposure control, reduced kV for small patients); paediatric protocols were created by weight band. Results are reviewed quarterly by the radiologist and radiographer lead.
AFTER	The Monitor reviewed three quarterly dose reports showing median doses below DRLs for all ten examinations after adjustment, and the new paediatric protocol set. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Extract last month's CTDIvol and DLP for your ten most common scans.
2. Find your national DRLs (or use EU/ACR references).
3. Compare. Any scan above the DRL needs protocol review.
4. Create paediatric protocols by weight if you have none.

The most common mistake: Scanning children on adult protocols — a child receives several times the necessary dose.

SELF-ASSESSMENT QUESTIONS

1. Is radiation dose tracked for every CT examination, not only sampled occasionally? — *Consistent tracking for every examination, not periodic spot-checking alone.*
Evidence: Dose tracking record
2. Is facility dose data periodically compared against a recognised external benchmark, not only reviewed internally? — *A real external reference point, not only comparison against the facility's own historical data.*
Evidence: Benchmarking comparison record
3. When dose consistently runs high against the benchmark, is the protocol actually reviewed and adjusted? — *Genuine review leading to*

action, not benchmarking data collected without consequence.

Evidence: Protocol review and adjustment record

COMMON REASONS FOR A PARTIAL ANSWER

- **Dose is tracked for common examination types but not less frequent ones.** — Every examination type carries the same real benchmarking value, not only high-volume ones.
- **Benchmarking happens but the comparison reference used is outdated.** — Reference levels are periodically updated, and comparison against an outdated benchmark may not reflect current best practice.
- **High-dose findings are noted but protocol review doesn't consistently follow.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current dose tracking coverage across all CT examination types.
Week 2	Establish or verify periodic comparison against a recognised, current external benchmark.
Week 3	Establish a defined process for protocol review when dose consistently runs high.
Ongoing	Repeat benchmarking comparison periodically and track resulting protocol changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Dose tracking review	Reviews dose tracking records for consistency across CT examinations.
DOCUMENT	Benchmarking record review	Reviews evidence of periodic comparison against a recognised external dose benchmark.
ASK	Protocol adjustment interview	Asks staff for a real example where benchmarking led to a protocol review or adjustment.

SUPERVISOR TIPS

- **Ask for actual benchmarking comparison data, not a general assurance that dose is monitored.** — Specific, dated comparison

records are the only real evidence of genuine benchmarking.

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

EVIDENCE BASE

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

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

NON-NEGOTIABLE

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

In plain terms: Every patient is verbally checked for metal, implants, and devices immediately before entering the MRI room, by going through their completed form question by question — not relying on a form filled in at reception.

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

WHY THIS MATTERS

An MRI magnet is always on. A ferromagnetic aneurysm clip twists and tears the vessel. A cochlear implant is destroyed. An unrecognised pacemaker stops. A steel oxygen cylinder brought into the room becomes a projectile that has killed patients. The written screening

form is necessary but not sufficient: patients forget, misunderstand, or tick 'no' by default. The verbal check — the radiographer going through the form with the patient at the door of the scan room, asking each question again — catches what the form missed. It takes two minutes and is the last chance.

WHAT GOOD LOOKS LIKE

- Every patient undergoes genuine verbal screening immediately before entering the scan room.
- The full questionnaire is reviewed in its entirety at that point.
- Patients are specifically asked to remove relevant items immediately before the scan.

COMMON FAILURE MODES

- Screening relies on an intake form completed earlier, without review at the point of scanning.
- Verbal review is abbreviated rather than covering the full questionnaire.
- Item removal is assumed rather than specifically checked.

WORKED EXAMPLE

IN PRACTICE

An imaging centre with a 1.5T MRI scanner.

BEFORE

Patients completed a screening form at reception. The radiographer glanced at it and proceeded. A patient with a programmable shunt valve, who had ticked 'no implants' because she did not think of it as an implant, was scanned; the valve setting was altered. A cleaner had once brought a steel bucket into the room.

ACTION	A two-stage screening process was implemented: the written form at reception; then, at the scan room door, the radiographer reads every question aloud, asks the patient to confirm, and probes for anything implanted, ever, anywhere. A ferromagnetic detector was installed at the door. Zone signage and access control were established per ACR guidance. All non-radiography staff who enter Zone III were trained. A checklist is signed by the radiographer before every scan.
AFTER	The Monitor observed three patients screened verbally at the door and the checklist signed. Reviewed zone signage and the detector. Interviewed a cleaner who described the access rules. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch a patient enter the scan room. Does the radiographer verbally re-screen at the door?
2. Make the verbal re-screen mandatory with a signed checklist.
3. Install zone signage and, if possible, a ferromagnetic detector.
4. Train every staff member who might enter the room.

The most common mistake: Trusting the reception form — patients do not know that a shunt valve, a stent, or a tattoo can matter.

SELF-ASSESSMENT QUESTIONS

1. Does every patient undergo a genuine verbal screening review immediately before entering the scan room, not only earlier intake screening? — *A real, verbal review at the actual point of entry, not reliance on an earlier form alone.*

Evidence: Pre-scan verbal screening record

2. Is the full written questionnaire reviewed in its entirety, not just a quick verbal confirmation? — *Complete review of every question, not an abbreviated check.*

Evidence: N/A — tested directly

3. Are patients specifically asked to remove jewellery, metallic clothing items, and similar objects immediately before the scan? — A specific, direct check, not an assumption the patient already did this.
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Verbal screening happens but is rushed during busy scheduling periods.** — A rushed screening risks missing exactly the detail this process exists to catch.
- **Screening is thorough for new patients but abbreviated for returning ones.** — A returning patient's circumstances — a new implant, a recent procedure — can genuinely have changed since their last scan.
- **The questionnaire is reviewed but item removal isn't specifically, separately confirmed.**

IMPLEMENTATION PLAN

When	What
Week 1	Observe current pre-scan screening practice for genuine, complete verbal review.
Week 2	Reinforce full questionnaire review immediately before scan room entry for every patient.
Week 3	Establish a specific, separate item-removal confirmation step.
Ongoing	Observe screening practice periodically, particularly during busy periods.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Pre-scan screening observation	Observes an actual pre-scan screening for genuine, complete verbal review immediately before entry.
DOCUMENT	Questionnaire completeness review	Reviews completed questionnaires for full coverage, not abbreviated screening.
ASK	Technologist practice interview	Asks a technologist to describe their specific pre-scan screening routine.

SUPERVISOR TIPS

- **Observe an actual pre-scan screening if timing allows.** — Direct observation reveals whether this is a genuine, complete review or an abbreviated formality.
- **Ask about screening for a returning patient specifically.** — This is where screening rigor most commonly, and riskily, relaxes in practice.

EVIDENCE BASE

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

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

16.3

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

CORE

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

In plain terms: If the imaging department gives contrast, its reaction protocol is the same as the one used everywhere else in the facility — one protocol, not several.

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

WHY THIS MATTERS

When a facility has a cath lab, an imaging department, and an oncology unit, each may have written its own contrast reaction protocol — with different drug doses, different escalation steps, different kit contents. A nurse who floats between departments faces three algorithms for one emergency. A facility-wide protocol, identical in

every location, means that anyone trained anywhere can respond correctly everywhere. This criterion is about consistency: one document, one kit list, one training programme.

WHAT GOOD LOOKS LIKE

- The imaging protocol is genuinely identical to the version used elsewhere in the facility.
- Protocol updates happen synchronously across departments.
- Staff training content is consistent across departments.

COMMON FAILURE MODES

- Imaging maintains its own separate protocol, independently developed.
- Imaging's protocol has visibly lagged behind updates made elsewhere.
- Staff in different departments describe meaningfully different protocols.

WORKED EXAMPLE

IN PRACTICE

A multi-specialty ambulatory centre with imaging, cardiology, and oncology all using contrast.

BEFORE

Three departments had three protocols, written at different times by different people. Adrenaline doses differed. One department's kit included items the others' did not. Nursing staff rotated between departments and were unsure which protocol applied.

ACTION

A facility-wide contrast reaction protocol was written by a working group from all three departments, based on current national guidance. One kit list. One laminated algorithm. One training module with an annual competency check. The three departmental protocols were withdrawn. The document is controlled with a review date and owner.

AFTER

The Monitor found the identical protocol and kit in all three departments, reviewed the single training record, and asked a rotating nurse which protocol applied; she pointed to the one. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Collect every contrast reaction protocol in the facility. Count them.
2. Compare the adrenaline doses. If they differ, that is the finding.
3. Write one protocol with a working group from all departments.
4. Withdraw the others and train everyone to the one.

The most common mistake: Each department writing its own version of a facility-wide emergency — the emergency does not know which department it is in.

SELF-ASSESSMENT QUESTIONS

1. Is the contrast reaction protocol used in imaging identical to the one used elsewhere in this facility, not independently maintained? — *A genuinely shared, single protocol, not two versions that happen to be similar.*

Evidence: Cross-department protocol comparison

2. When the shared protocol is updated, does imaging's version update at the same time, not lag behind? — *Synchronised updates, not a separate update cycle for each department.*

Evidence: Protocol update record and timing

3. Are staff in imaging trained on the same protocol version as staff elsewhere in the facility? — *Consistent training content, not department-specific variations.*

Evidence: Training record comparison

COMMON REASONS FOR A PARTIAL ANSWER

- **Protocols were identical when first established but have since quietly diverged.** — Without an active synchronisation process, separately maintained copies of the same protocol drift apart over time.
- **The core protocol matches but emergency medication stock differs between departments.** — A protocol match without matching resources doesn't provide the same real readiness.
- **Staff in imaging know the protocol exists but haven't been trained on the most recent update.**

IMPLEMENTATION PLAN

When	What
Week 1	Directly compare imaging's contrast protocol against the version used elsewhere in the facility.
Week 2	Resolve any divergence found, establishing one genuinely shared protocol.
Week 3	Establish a synchronised update process across departments.
Ongoing	Periodically reconfirm protocol consistency across departments.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Cross-department protocol comparison	Compares the imaging department's contrast protocol directly against the version used elsewhere in the facility.
DOCUMENT	Update synchronisation review	Reviews update records to confirm imaging's protocol updates in sync with the shared version.
ASK	Staff training consistency interview	Asks imaging staff to describe the protocol and compares against what other departments describe.

SUPERVISOR TIPS

- **Ask for the actual protocol documents from both departments and compare them directly.** — Direct comparison is the only real evidence of genuine consistency, not assumed alignment.
- **Ask staff in each department the same specific question and compare answers.** — Consistent answers reveal genuine shared training; differing answers reveal quiet divergence.

EVIDENCE BASE

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

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**Standard 17 — Dermatology
→**

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Standard 17 — Dermatology

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

CRITERIA IN THIS STANDARD

- 17.1 — Biopsy Specimens Are Tracked to a Confirmed Pathology Result
- 17.2 — Cryotherapy and In-Office Procedures Follow a Defined Safety Protocol
- 17.3 — Phototherapy Dosing Follows Evidence-Based Protocol, Not Estimation
- 17.4 — Suspicious Lesions Have a Defined, Timed Escalation Path

17.1 Biopsy Specimens Are Tracked to a Confirmed Pathology Result

NON-NEGOTIABLE

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

In plain terms: Every skin biopsy is tracked from the moment it is taken until the pathology result is reviewed and the patient told — a named person makes sure none is lost.

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

WHY THIS MATTERS

A melanoma biopsy that is lost, or whose result sits unread, or whose result is read but the patient is never contacted, is a death sentence delivered by administrative failure. Dermatology practices take many biopsies; most are benign; the system relaxes; and the one malignant result that matters is the one that slips through. Tracking means a log — specimen taken, sent, result received, reviewed, patient informed — with dates at each stage, checked weekly for gaps, and owned by a named person. Every entry must reach 'patient informed' or the log flags it.

WHAT GOOD LOOKS LIKE

- A specific, dedicated biopsy tracking process exists, distinct from general results.
- The system can identify and surface a specimen whose result was never received.
- Patient communication of the result is itself tracked, not assumed.

COMMON FAILURE MODES

- Biopsies are tracked only within a general test-result system, with no distinct process.
- There is no way to identify a specimen that fell through the cracks.
- Communication to the patient is assumed but not actually tracked.

WORKED EXAMPLE

IN PRACTICE

A dermatology clinic taking 60 biopsies a month.

BEFORE

Specimens were sent to the lab with a request form. Results came back by post and were filed in the patient's notes for review at the next appointment. No log existed. When the Coordinator reviewed three months of lab records against patient notes, four results had never been reviewed — one was a melanoma, now four months old.

ACTION

A biopsy log was created: date taken, patient, site, date sent, expected result date, date received, date reviewed by clinician, date patient informed, action. The practice nurse owns it and checks it weekly. Any result not received within 14 days is chased. Any result not reviewed within 48 hours of receipt is escalated. Any patient not informed within 7 days of review is called. Malignant results trigger same-day patient contact.

AFTER

The Monitor reviewed the log for three months: 180 biopsies, all reaching 'patient informed'; median time from result to patient contact 3 days; two melanomas identified and referred within 24 hours. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Get your lab's list of specimens received from you last month.
Match each to a reviewed result in your records.
2. Start a biopsy log with all stages and dates.
3. Name one person to own it and check weekly.
4. Set a rule: malignant results → patient contacted same day.

The most common mistake: Filing results for review at the next appointment — the melanoma patient may not have one booked.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, named tracking process for biopsy specimens, distinct from general test result tracking? — *A dedicated process specifically for biopsies, given the distinct severity risk.*

Evidence: Biopsy tracking log

2. Is there a way to identify a biopsy specimen whose result was never actually received or reviewed? — *An active mechanism that surfaces a gap, not one that only shows completed results.*

Evidence: Uncollected result identification process

3. Is the confirmed result specifically communicated to the patient, with the communication itself tracked? — *Tracked communication, not an assumption the patient was informed because the result exists in the*

chart.

Evidence: Patient communication tracking record

COMMON REASONS FOR A PARTIAL ANSWER

- **Tracking exists for biopsies taken by the primary dermatologist but not consistently for those taken by covering staff.** — Every biopsy carries the same real risk, regardless of who performed it.
- **The tracking log exists but isn't reviewed on a regular schedule to catch gaps.** — A log that isn't actively reviewed provides limited real protection against a missed result.
- **Results are tracked internally but patient communication specifically isn't logged.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current biopsy tracking practice for a specific, dedicated process.
Week 2	Establish a tracking log covering every biopsy from collection to confirmed, communicated result.
Week 3	Build a mechanism to actively surface any specimen without a received result.
Ongoing	Review the tracking log on a regular schedule for gaps.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Biopsy tracking log review	Reviews the specific biopsy tracking log for completeness from collection to confirmed result.
OBSERVE	Uncollected result identification check	Checks whether the tracking system can actually surface a specimen whose result was never received.
DOCUMENT	Patient communication tracking review	Reviews evidence that result communication to the patient is itself tracked, not assumed.

SUPERVISOR TIPS

- **Ask for the actual tracking log and pick a specific, older biopsy to trace through it.** — Tracing a real, specific case reveals whether

the system genuinely works, not just whether it exists.

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

EVIDENCE BASE

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

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17.2 Cryotherapy and In-Office Procedures Follow a Defined Safety Protocol

NON-NEGOTIABLE

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

In plain terms: Cryotherapy, curettage, and other in-office skin procedures follow a written protocol for technique, depth, and aftercare — not each clinician's personal habit.

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

WHY THIS MATTERS

Cryotherapy applied too long causes scarring, nerve damage, and depigmentation; applied too briefly it fails and the lesion — which may be malignant — recurs. Curettage without a defined margin leaves tumour behind. Aftercare instructions that vary by clinician confuse patients and cause infections. A protocol per procedure states the

technique, the freeze time and cycles by lesion type, the margin, the aftercare, and when to review. It makes outcomes consistent and auditable. 'I've been doing it this way for years' is not a protocol.

WHAT GOOD LOOKS LIKE

- A defined, documented protocol governs technique and treatment depth.
- Lesion suitability for cryotherapy versus biopsy is genuinely assessed before treatment.
- Post-procedure instruction is consistent and procedure-specific.

COMMON FAILURE MODES

- Technique and depth vary by individual practitioner without a documented standard.
- Suspicious lesions are treated without a genuine biopsy-versus-treatment decision.
- Post-procedure instruction is generic or inconsistently given.

WORKED EXAMPLE

IN PRACTICE

A dermatology clinic with three clinicians performing cryotherapy and curettage.

BEFORE

Each clinician had their own approach. Freeze times were by feel. Aftercare instructions were verbal and inconsistent. A patient developed a large hypopigmented scar on the face after prolonged cryotherapy for a seborrhoeic keratosis. Another had a basal cell carcinoma recur after curettage with no defined margin.

ACTION

Protocols were written for the five most common in-office procedures, based on national dermatology guidance: indications, contraindications, technique, freeze time and cycle count by lesion type and site, margin for curettage, written aftercare instructions, and review timing. All clinicians agreed to follow them. A quarterly audit of ten procedures checks compliance and outcome.

AFTER

The Monitor reviewed the protocols, the aftercare sheets, and two quarterly audits showing

compliance and no scarring complaints in the period. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask each clinician how long they freeze a plantar wart. If the answers differ, that is the gap.
2. Write a protocol per common procedure with freeze times by lesion and site.
3. Standardise written aftercare.
4. Audit ten procedures a quarter.

The most common mistake: Treating cryotherapy as trivial — it is a destructive procedure with permanent consequences when done wrong.

SELF-ASSESSMENT QUESTIONS

1. Does the practice follow a defined protocol for technique and treatment depth matched to lesion type? — *A specific, documented protocol, not individual practitioner habit alone.*
Evidence: Procedure protocol document
2. Is there a documented process for confirming a lesion's suitability for cryotherapy before treating, rather than a suspicious lesion being frozen without biopsy consideration? — *A specific decision point, not automatic treatment without considering whether biopsy is warranted first.*
Evidence: Lesion suitability assessment record
3. Is post-procedure care instruction given consistently, specific to the procedure performed? — *Consistent, procedure-specific instruction, not generic aftercare advice.*
Evidence: Post-procedure instruction documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **The protocol is followed by the primary dermatologist but not consistently by covering or newer staff.** — Consistency needs to extend to everyone performing the procedure, not only the most experienced practitioner.
- **Lesion suitability assessment happens for obviously ambiguous cases but not routinely for all lesions.** — The decision to treat rather than biopsy deserves genuine consideration for every lesion, not only the visually ambiguous ones.

- **Post-procedure instruction is given verbally but not consistently provided in writing.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current technique and depth practice for consistency against a defined protocol.
Week 2	Establish or reinforce a genuine lesion-suitability assessment step before treatment.
Week 3	Standardise written post-procedure instruction specific to each procedure type.
Ongoing	Audit protocol consistency across all practitioners performing procedures.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Protocol review	Reviews the defined technique and depth protocol against actual practice.
OBSERVE	Lesion suitability assessment observation	Observes whether lesion suitability for cryotherapy versus biopsy is genuinely assessed before treatment.
DOCUMENT	Post-procedure instruction review	Reviews post-procedure care documentation for consistency and procedure specificity.

SUPERVISOR TIPS

- **Ask a practitioner to describe their decision process for a specific, recent case.** — Specificity reveals whether a genuine, consistent protocol is followed, not individual habit.
- **Ask what would prompt biopsy instead of direct treatment for an ambiguous lesion.** — A confident, specific answer reveals genuine, consistent clinical judgement embedded in practice.

EVIDENCE BASE

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

17.3 Phototherapy Dosing Follows Evidence-Based Protocol, Not Estimation

NON-NEGOTIABLE

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

In plain terms: UV phototherapy doses start from a measured or skin-type-based baseline and increase according to written rules based on the patient's skin response — not by guesswork.

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

WHY THIS MATTERS

Phototherapy is a controlled burn. Too much UV causes painful erythema, blistering, and — cumulatively — skin cancer. Too little wastes the patient's time and delays treatment. The starting dose must be individualised: either a minimal erythema dose test or a validated skin-phototype schedule. Each subsequent dose depends on the response to the last: no erythema → increase by a defined percentage; mild → hold; painful → reduce or skip. Cumulative dose is tracked against lifetime limits. A unit that increases 'by feel' will burn some patients and undertreat others.

WHAT GOOD LOOKS LIKE

- Initial dose is based on minimal erythema dose testing or a defined skin-phototype protocol.
- Dose adjustment follows specific, evidence-based

COMMON FAILURE MODES

- Initial dose is estimated without a defined protocol.
- Dose adjustment is based on general practitioner judgement without specific rules.

rules tied to erythema response.

- Cumulative UV exposure is tracked over the full course of treatment.

- Cumulative exposure isn't tracked beyond individual session records.

WORKED EXAMPLE

IN PRACTICE

A dermatology clinic with a narrowband UVB cabinet treating 40 patients.

BEFORE

Starting doses were chosen by the nurse's impression of skin type. Increases were 'about 20% if it looked OK.' Erythema was not systematically recorded. Cumulative doses were not tracked. Three patients had been burned in the previous year; one was a skin type II patient started on a type IV dose.

ACTION

A phototherapy protocol was adopted from national guidance: MED testing for all new patients, or skin-phototype starting dose where MED testing is impractical; an erythema score recorded before each treatment; dose adjustment rules by score (0 → +20%, 1 → +10%, 2 → hold, 3+ → reduce and review); cumulative dose logged and reviewed at 200 treatments. Cabinet output is measured quarterly.

AFTER

The Monitor reviewed 20 patient phototherapy records with MED or phototype baselines, erythema scores at each visit, rule-based adjustments, and cumulative doses. Cabinet calibration certificate on file. No burns in six months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten phototherapy records: is the starting dose justified? Is erythema scored each visit?
2. Adopt a national phototherapy protocol with adjustment rules.
3. Start MED testing or use a validated phototype schedule.

4. Track cumulative dose and calibrate the cabinet quarterly.

The most common mistake: Increasing the dose by a fixed amount each visit regardless of the patient's response.

SELF-ASSESSMENT QUESTIONS

1. Is initial phototherapy dose based on minimal erythema dose testing or a defined skin-phototype protocol? — *A specific, evidence-based starting point, not an estimated or arbitrary initial dose.*

Evidence: Initial dosing protocol document

2. Does dose adjustment follow specific, defined rules based on the patient's actual erythema response? — *A specific rule set, not practitioner judgement applied inconsistently.*

Evidence: Dose adjustment protocol

3. Is cumulative UV exposure tracked over the course of treatment, not just each session's dose in isolation? — *Tracked cumulative exposure, since total lifetime UV exposure carries its own real, distinct risk.*

Evidence: Cumulative exposure tracking record

COMMON REASONS FOR A PARTIAL ANSWER

- **Initial dosing follows the protocol but adjustment decisions become less rule-based as treatment continues.** — Adjustment discipline matters throughout the full course, not only at initiation.
- **Dosing records exist per session but aren't summed to show cumulative exposure.** — Individual session records don't reveal the cumulative exposure picture that carries its own distinct risk.
- **The protocol is followed for standard cases but less consistently for patients on photosensitising medications.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current dosing practice against minimal erythema dose or skin-phototype protocol standards.
Week 2	Establish specific, documented dose adjustment rules based on erythema response.
Week 3	Build cumulative UV exposure tracking into the treatment record.

When	What
Ongoing	Audit dosing decisions against the defined protocol periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Initial dosing protocol review	Reviews initial dosing practice against minimal erythema dose or skin-phototype protocol standards.
DOCUMENT	Dose adjustment record review	Reviews dose adjustment records against specific, evidence-based erythema response rules.
DOCUMENT	Cumulative exposure tracking review	Reviews whether cumulative UV exposure is tracked over the full course of treatment.

SUPERVISOR TIPS

- **Ask for the specific dose adjustment rule used for a documented erythema response.** — A specific, correct answer reveals genuine protocol-based practice, not general estimation.
- **Ask to see cumulative exposure tracking for a patient partway through a treatment course.** — This reveals whether cumulative risk is genuinely tracked, not just individual sessions.

EVIDENCE BASE

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

Train your team: AMB-17 · Dermatology on GMJ Academy →

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

17.4 Suspicious Lesions Have a Defined, Timed Escalation Path

NON-NEGOTIABLE

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

In plain terms: A lesion that looks suspicious has a fixed path — biopsy within a set time, referral to a specialist if needed — that is followed, not decided case by case.

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

WHY THIS MATTERS

A melanoma thickens by a fraction of a millimetre a week, and thickness determines survival. A suspicious lesion that waits three weeks for a biopsy appointment, then two weeks for a result, then a month for a referral, has been given ten weeks to grow. A defined pathway sets clocks: suspicious lesion identified → biopsy within 7 days → result reviewed within 48 hours → if malignant, referral sent within 24 hours and confirmed received. The pathway is written, everyone knows it, and it is audited. Urgency should not depend on which clinician saw the patient or how busy the day was.

WHAT GOOD LOOKS LIKE

- A specific, defined timeframe governs suspicious lesion biopsy.
- A specific, named referral pathway exists for advanced management.
- Adherence to the timeframe is actively tracked, not assumed.

COMMON FAILURE MODES

- Suspicious lesions are scheduled through routine, non-expedited booking.
- No specific referral pathway exists beyond general intention.
- No tracking exists to confirm the defined timeframe is actually being met.

WORKED EXAMPLE

IN PRACTICE

A dermatology clinic with a two-to-three-week wait for biopsy appointments.

BEFORE	Suspicious lesions were booked into the next available biopsy slot. Results were reviewed at the patient's next appointment. Referrals to the melanoma unit went by letter. The Coordinator traced three melanoma diagnoses from the previous year: median time from first visit to specialist referral was 52 days.
ACTION	A suspicious lesion pathway was written: any lesion meeting defined criteria (ABCDE, new or changing pigmented lesion, non-healing ulcer) → same-week biopsy slot (three reserved per week); result flagged urgent to the lab; reviewed within 48 hours of receipt; if malignant → same-day phone call to patient and electronic referral to the melanoma unit with phone confirmation. The pathway is audited monthly with time-to-referral tracked.
AFTER	The Monitor reviewed the pathway, the reserved slot system, and six months of tracking: median first visit to referral 9 days for malignant lesions. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Trace your last three malignant skin diagnoses: how long from first visit to specialist referral?
2. Write suspicious lesion criteria and a timed pathway.
3. Reserve biopsy slots each week for urgent lesions.
4. Track time-to-referral monthly.

The most common mistake: Booking a suspicious lesion into the routine biopsy queue — the routine queue is designed for lesions that can wait.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, defined timeframe for biopsying a lesion identified as suspicious, not routine scheduling? — *A specific, known*

timeframe, not folded into normal appointment availability.

Evidence: Escalation timeframe protocol

2. Is there a defined referral pathway to advanced management when findings warrant it? — *A specific, named pathway, not a general intention to refer if needed.*

Evidence: Referral pathway document

3. Is adherence to the escalation timeframe actually tracked, not assumed from the pathway existing on paper? — *Genuine tracking of actual timeframes achieved, not an assumption the pathway is followed.*

Evidence: Escalation timeframe adherence record

COMMON REASONS FOR A PARTIAL ANSWER

- **A timeframe is defined but not consistently communicated to scheduling staff.** — A defined standard that scheduling staff don't know about doesn't reliably translate into faster action.
- **The referral pathway exists but hasn't been used recently, so its current functioning is unverified.** — An untested pathway may not translate smoothly into real use when actually needed.
- **Tracking exists but isn't reviewed for patterns of delay.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current suspicious lesion scheduling against any existing timeframe standard.
Week 2	Define or reinforce a specific escalation timeframe and communicate it to scheduling staff.
Week 3	Confirm the referral pathway for advanced management is current and functioning.
Ongoing	Track and review actual timeframe adherence for patterns.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Escalation timeframe review	Reviews the specific, defined timeframe for suspicious lesion biopsy.
DOCUMENT	Referral pathway review	Reviews the specific, named referral pathway for advanced management.

Method	What	Detail
DOCUMENT	Adherence tracking review	Reviews records tracking whether the defined escalation timeframe is actually being met.

SUPERVISOR TIPS

- **Ask scheduling staff specifically what happens when a lesion is flagged as suspicious.** — This reveals whether the defined timeframe genuinely reaches the people responsible for scheduling.
- **Ask for a real, recent example of the referral pathway being used.** — A real example reveals whether the pathway genuinely functions, not just exists on paper.

EVIDENCE BASE

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

Train your team: AMB-17 · Dermatology on GMJ Academy →

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

← **Ambulatory Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 16 — Diagnostic Imaging**

Standard 18 — Allergy & Immunotherapy →

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Standard 18 — Allergy & Immunotherapy

3 criteria · 3 non-negotiable · 0 core · Version 3.0

CRITERIA IN THIS STANDARD

- 18.1 — Post-Injection Observation Time Is Enforced, Not Assumed
- 18.2 — Dose Escalation Follows a Defined, Individualized Schedule
- 18.3 — Extract Preparation and Labeling Prevents Vial Mix-Up

18.1 Post-Injection Observation Time Is Enforced, Not Assumed

NON-NEGOTIABLE

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

In plain terms: After every allergy shot, the patient stays in the clinic for the full observation period — the clinic enforces it, and does not let the patient decide to leave early.

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

WHY THIS MATTERS

Allergen immunotherapy injects the substance the patient is allergic to. Systemic reactions — including anaphylaxis — occur in about 1 in 1,000 injections, and most begin within 30 minutes. A patient who leaves at 10 minutes and reacts in the car park has no adrenaline and no one to give it. The 30-minute observation (longer for high-risk patients) is not advice; it is a requirement. Enforcement means: the patient signs in at injection time, is not discharged until the period is complete and a staff member has checked them, and a patient who insists on leaving early signs an against-advice form and is reconsidered for continued treatment.

WHAT GOOD LOOKS LIKE

- The minimum observation period is genuinely enforced for every patient.
- Departure time is recorded and verifiably matches or exceeds the required period.
- A specific, known process exists for extending observation when symptoms develop.

COMMON FAILURE MODES

- Patients are permitted to leave early based on how they feel.
- No record exists comparing injection time against actual departure time.
- Staff are uncertain what happens if symptoms develop during observation.

WORKED EXAMPLE

IN PRACTICE

An allergy clinic giving 80 immunotherapy injections a week.

BEFORE

Patients were told to wait 30 minutes. Many left after 10 to get to work. No one checked. A patient developed anaphylaxis in the car 15 minutes after leaving; he survived because a passing pharmacist had adrenaline. The clinic had no enforcement mechanism.

ACTION

An observation protocol was implemented: injection time recorded on a wristband; the patient sits in a designated area visible from the nurses' station; discharge only after 30 minutes (45 for high-risk) and a nurse check of symptoms and vital signs, documented; a patient who insists

on leaving early signs a form and their case is reviewed by the allergist for suitability to continue. Adrenaline and the anaphylaxis kit are at the observation area.

AFTER

The Monitor observed the waiting area with wristbands, reviewed 30 injection records with documented 30-minute checks, and two early-leaver forms with follow-up review. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch three patients after their injection. How long do they actually stay?
2. Introduce a time-stamped wristband and a documented discharge check.
3. Put the anaphylaxis kit in the observation area.
4. Write the early-leaver procedure.

The most common mistake: Advising a 30-minute wait and treating it as the patient's choice — a reaction in the car park is the clinic's failure.

SELF-ASSESSMENT QUESTIONS

1. Is the minimum observation period actually enforced for every patient, not left to the patient's own judgement? — *Genuinely enforced, not a recommendation the patient can opt out of by feeling ready to leave.*

Evidence: Observation enforcement protocol

2. Is the patient's departure time actually recorded and compared against injection time? — *A real, checkable record, not an assumption the full period was observed.*

Evidence: Departure time tracking record

3. Is there a specific process for extending observation if symptoms develop during the standard window? — *A defined, known extension process, not uncertainty about what happens if something develops.*

Evidence: Extended observation protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Observation is enforced during busy periods when staff are actively monitoring the waiting area, but less consistently when the area is quiet.** — The requirement doesn't depend on how busy the facility happens to be at the time.
- **Departure time is recorded but not actually compared against injection time to verify compliance.** — A recorded time that's never checked against the requirement doesn't provide real verification.
- **Extension happens for obvious reactions but the threshold for what warrants extension isn't clearly defined.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current observation practice for genuine enforcement, not patient-judgement-based departure.
Week 2	Establish a recorded departure time process, compared against injection time.
Week 3	Define and brief staff on a specific extended observation protocol.
Ongoing	Audit departure time records against the minimum requirement periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Observation enforcement check	Observes actual practice to confirm patients are genuinely held for the minimum period, not permitted to leave early.
DOCUMENT	Departure time record review	Reviews records comparing injection time against actual departure time for a sample of patients.
ASK	Extended observation interview	Asks staff what happens specifically if symptoms develop during the standard observation window.

SUPERVISOR TIPS

- **Ask to see actual departure time records compared against injection times for real patients.** — Specific, dated records are the only real evidence the requirement is genuinely enforced.
- **Observe the waiting area during a quiet period specifically.** — Enforcement is most likely to relax exactly when the area feels calm and unhurried.

EVIDENCE BASE

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

Train your team: AMB-18 · Allergy & Immunotherapy on GMJ Academy →

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

18.2 **Dose Escalation Follows a Defined, Individualized Schedule**

NON-NEGOTIABLE

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

In plain terms: Immunotherapy doses increase on a written schedule adjusted for each patient — missed doses, previous reactions, high-risk factors — not advanced automatically by the calendar.

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

WHY THIS MATTERS

The build-up phase increases the allergen dose step by step to reach maintenance. A patient who missed two weeks and then receives the next scheduled increase has jumped several steps and may react. A patient who had a large local reaction last time needs the dose held or reduced, not increased. A patient with asthma, on beta-blockers, or during pollen season, is at higher risk and needs a slower schedule. The clinic must have a written schedule per extract, written rules for adjustment, and a check before every injection: what was the last dose, what was the reaction, how long ago, what has changed?

WHAT GOOD LOOKS LIKE

- Missed doses trigger a specific, defined adjustment to the escalation schedule.
- A prior reaction genuinely changes subsequent dose decisions.
- Dose and escalation status are actively verified against the record before each injection.

COMMON FAILURE MODES

- Doses advance automatically according to a calendar regardless of missed visits.
- Prior reactions don't change subsequent dosing decisions.
- Dose is assumed from time elapsed rather than verified against the actual record.

WORKED EXAMPLE

IN PRACTICE

An allergy clinic with 120 patients in immunotherapy build-up.

BEFORE

The schedule was printed on a card; the nurse gave the next dose on the card regardless of interval or prior reaction. A patient who had missed four weeks received the next dose and developed anaphylaxis. Another with asthma exacerbation was not asked about it and reacted.

ACTION

Dose adjustment rules were written per national guidance: missed doses → step back by a defined number of steps depending on interval; large local reaction → repeat dose; systemic reaction → reduce and allergist review; asthma unstable, beta-blocker started, or peak pollen → hold and review. A pre-injection checklist is

completed every visit: last dose date, last reaction, current symptoms, medication changes, peak flow for asthmatics. The nurse cannot give a dose that deviates from the rules without allergist sign-off.

AFTER

The Monitor reviewed 30 injection records with completed pre-injection checklists and rule-based adjustments; five showed step-backs after missed doses. Systemic reactions in six months: 0. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask your nurse what happens if a patient has missed three weeks. If the answer is 'give the next dose,' that is the gap.
2. Write adjustment rules for missed doses, reactions, and risk factors.
3. Add a pre-injection checklist to every visit.
4. Require allergist sign-off for any deviation.

The most common mistake: Following the card schedule regardless of what has happened since the last injection.

SELF-ASSESSMENT QUESTIONS

1. Is dose escalation adjusted for missed doses, not advanced automatically as if the prior visit occurred on schedule? — *A specific, defined adjustment rule for missed doses, not automatic progression.*

Evidence: Missed-dose adjustment protocol

2. Is dose escalation adjusted based on any reaction at the prior dose, not proceeding regardless? — *Genuine responsiveness to prior reaction history for this specific patient.*

Evidence: Prior-reaction dose adjustment record

3. Is the current dose and escalation status verified before each injection, not assumed from the calendar? — *An active check against the patient's actual record, not assumed from how much time has passed.*

Evidence: Pre-injection dose verification record

COMMON REASONS FOR A PARTIAL ANSWER

- **Missed-dose adjustment happens for longer gaps but not shorter, still-relevant delays.** — Even a shorter-than-expected gap can carry meaningful risk depending on the specific interval.
- **Prior reactions are noted in the record but don't consistently change the next dose decision.** — A noted reaction that doesn't influence the subsequent decision doesn't provide the protection this criterion is meant to ensure.
- **Verification happens for new or unusual cases but becomes less rigorous for routine, long-established patients.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current escalation practice for genuine adjustment based on missed doses and prior reactions.
Week 2	Establish or reinforce a specific, defined missed-dose adjustment rule.
Week 3	Build active pre-injection verification into the standard workflow for every patient.
Ongoing	Audit escalation decisions against missed-dose and prior-reaction adjustment rules.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Missed-dose adjustment review	Reviews records for evidence that missed doses trigger a defined adjustment, not automatic progression.
DOCUMENT	Prior-reaction adjustment review	Reviews whether a prior reaction genuinely changes the subsequent dose decision.
OBSERVE	Pre-injection verification observation	Observes whether dose and escalation status are actively verified against the patient's record before each injection.

SUPERVISOR TIPS

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

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

EVIDENCE BASE

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

Train your team: AMB-18 · Allergy & Immunotherapy on GMJ Academy →

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

18.3 Extract Preparation and Labeling Prevents Vial Mix-Up

NON-NEGOTIABLE

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

In plain terms: Allergen extracts are prepared, diluted, and labelled by a defined process that prevents one patient's vial being used for another — with an independent check before every injection.

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

WHY THIS MATTERS

Each patient's extract is unique — their allergens, their concentration. Giving patient A's maintenance-strength extract to patient B, who is on a low build-up dose of a different allergen, can cause fatal anaphylaxis. Vials look identical. Names are similar. Storage is a shared fridge.

Prevention means: patient-specific labelling with two identifiers and the concentration; a defined dilution procedure with a second-person check; storage segregated by patient; and, before every injection, an independent check of the vial against the patient's identity and schedule — read aloud, by someone other than the person drawing up.

WHAT GOOD LOOKS LIKE

- A specific, defined process prevents vial mix-up in preparation and labeling.
- A genuine, independent vial-to-patient check happens before every administration.
- Labeling is specifically checked, not just present.

COMMON FAILURE MODES

- No specific mix-up prevention process exists beyond general care.
- Vial verification isn't genuinely independent or is folded loosely into general patient identification.
- Labels exist but aren't specifically checked before administration.

WORKED EXAMPLE

IN PRACTICE

An allergy clinic preparing extracts for 150 patients in a shared refrigerator.

BEFORE

Vials were labelled with surname only. Dilutions were prepared by one nurse without a check. The fridge held all vials alphabetically. Two patients named Petrov had vials adjacent; the wrong one was used, causing a systemic reaction. No independent pre-injection check was performed.

ACTION

Labelling was standardised: full name, date of birth, allergen mix, concentration, date prepared, expiry. Dilutions are prepared by one nurse and checked by a second, both signing. Each patient's vials are stored in a labelled individual box. Before injection, a second staff member reads the vial label against the patient's wristband and schedule aloud, and both sign. Same-name patients are flagged in the system.

AFTER

The Monitor observed two injections with independent vial checks, inspected the fridge with individual patient boxes, and reviewed 30 records with double signatures. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Open your extract fridge. Are vials labelled with two identifiers?
Are same-name patients adjacent?
2. Standardise labels and store each patient's vials in a labelled box.
3. Require a second-person check on every dilution.
4. Require an independent vial-to-patient check before every injection.

The most common mistake: Labelling vials with surname only — two Petrovs in one fridge is a disaster waiting.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined process for preparing and labeling extract vials that specifically prevents mix-up between patients? — *A specific, designed process, not general care assumed to be sufficient.*

Evidence: Extract preparation and labeling protocol

2. Is there a genuine, independent check confirming the correct vial for the correct patient before administration, distinct from general patient identification? — *A specific vial-to-patient check, not folded into or assumed covered by general identification.*

Evidence: Vial verification record

3. Are vials specifically labeled with concentration and patient identity in a way that's checked, not just present? — *Genuinely checked labeling, not assumed correct because a label exists.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification is rigorous when a single patient is being seen but becomes less consistent during busy periods with multiple patients.** — Mix-up risk is highest exactly when multiple vials for different patients are present simultaneously.
- **Labeling includes patient name but concentration isn't consistently double-checked.** — Correct patient with incorrect

concentration still represents a real, distinct risk.

- **The check happens but isn't genuinely independent — the same person prepares and verifies.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current extract preparation and labeling practice for mix-up prevention specificity.
Week 2	Establish a genuine, independent vial-to-patient verification step before every administration.
Week 3	Reinforce labeling practice to include both patient identity and concentration, both checked.
Ongoing	Observe verification practice periodically, particularly during busy periods with multiple patients.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Preparation and labeling protocol review	Reviews the defined process for extract preparation and labeling specific to mix-up prevention.
OBSERVE	Vial verification observation	Observes an actual pre-administration check for genuine, independent vial-to-patient verification.
ASK	Labeling practice interview	Asks staff to describe how they confirm vial concentration and patient identity match before administering.

SUPERVISOR TIPS

- **Observe during a period when multiple patients are being seen for injections.** — This is exactly when mix-up risk is highest and verification discipline most likely to be tested.
- **Ask whether the same person both prepares and verifies, or whether this is genuinely independent.** — Genuine independence between preparation and verification is what distinguishes a real check from a formality.

EVIDENCE BASE

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

Train your team: AMB-18 · Allergy & Immunotherapy on GMJ Academy →

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

← Ambulatory Clinic
Standards — all standards

Self-assess against these
criteria →

← Standard 17 —
Dermatology

Standard 19 — Plastic &
Cosmetic Surgery →

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ASF STANDARDS · AMBULATORY CLINIC · STANDARD 19

Standard 19 — Plastic & Cosmetic Surgery

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CRITERIA IN THIS STANDARD

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

**19.2 — Office-Based Anesthesia
Follows Defined Safety
Standards**

**19.3 — Patient Selection
Excludes Those Outside Safe
Office-Based Surgery Criteria**

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

NON-NEGOTIABLE

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

In plain terms: For any office surgery under general anaesthesia lasting over an hour, the physician — not the patient — completes a validated blood-clot risk score and decides on prophylaxis before the operation.

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

WHY THIS MATTERS

Cosmetic surgery patients are often healthy — which is exactly why VTE is overlooked. A four-hour abdominoplasty under general anaesthesia, in a patient on oestrogen with a BMI of 32, carries a substantial clot risk. Pulmonary embolism is the leading cause of death after office-based cosmetic surgery. The Caprini score, completed by the surgeon from the patient's history and the planned procedure, stratifies risk and mandates prophylaxis — mechanical for most, chemical for higher scores. A questionnaire the patient fills in at reception is not a risk assessment; the surgeon must own it.

WHAT GOOD LOOKS LIKE

- The VTE risk score is completed by the physician for every applicable procedure.
- The prophylaxis decision genuinely reflects the documented risk category.
- The score is reassessed if the actual procedure differs from what was planned.

COMMON FAILURE MODES

- The risk score is completed by the patient, or not completed at all.
- Prophylaxis decisions don't consistently reflect the documented risk score.
- The score isn't reassessed even when the procedure scope changes significantly.

WORKED EXAMPLE

IN PRACTICE

An office-based plastic surgery practice performing abdominoplasty, liposuction, and breast surgery.

BEFORE

A VTE questionnaire was in the intake pack; patients ticked boxes. The surgeon did not review or score it. Prophylaxis was 'compression stockings if we remember.' A 38-year-old on oral contraceptives died of pulmonary embolism five days after abdominoplasty.

ACTION

The Caprini score was adopted, completed by the surgeon at the pre-operative consultation from a

structured history, and recorded with the planned procedure. Prophylaxis is prescribed by score: intermittent pneumatic compression for all; LMWH for Caprini ≥ 7 (or per national guidance); oestrogen-containing medication stopped four weeks pre-op for scores above threshold. The score and plan are on the theatre checklist; surgery does not proceed without them.

AFTER

The Monitor reviewed 20 operative records: all had surgeon-completed Caprini scores with prophylaxis matched to score; three showed oestrogen cessation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten operative records: is there a VTE score, and who completed it?
2. Adopt the Caprini score and require surgeon completion.
3. Write prophylaxis rules by score.
4. Add score and plan to the theatre checklist.

The most common mistake: Assuming young, healthy cosmetic patients are low risk — the combination of long surgery, oestrogen, and immobility is high risk.

SELF-ASSESSMENT QUESTIONS

1. Is a validated VTE risk score completed by the physician, not the patient, for every applicable procedure? — *Physician-completed specifically, not relying on patient self-report.*

Evidence: VTE risk assessment record

2. Does the resulting risk category actually determine the prophylaxis decision, not just get recorded and set aside? — *Genuine, documented decision-making tied to the score, not a score calculated but not acted on.*

Evidence: Prophylaxis decision record linked to risk score

3. Is the risk score specifically re-assessed if the planned procedure changes in scope or duration? — *Reassessment reflecting the actual procedure performed, not the originally planned one.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The score is physician-completed for major procedures but skipped for shorter or perceived lower-risk cases.** — The 60-minute general anesthesia threshold, not a subjective sense of procedure risk, is what determines whether scoring applies.
- **The score is completed but prophylaxis decisions default to a standard approach regardless of the specific category.** — The whole value of risk stratification is lost if prophylaxis doesn't actually vary by category.
- **Reassessment happens when the surgeon proactively remembers, without a defined trigger.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current VTE risk assessment practice for physician completion versus patient self-report.
Week 2	Establish or reinforce genuine linkage between risk category and prophylaxis decision.
Week 3	Define a specific trigger for reassessment when procedure scope changes.
Ongoing	Audit risk score completion and prophylaxis decision consistency periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Risk score completion review	Reviews records confirming the VTE risk score was completed by the physician, not the patient.
DOCUMENT	Prophylaxis decision review	Reviews whether the prophylaxis decision is genuinely tied to the documented risk score.
ASK	Reassessment practice interview	Asks the physician whether and how the score is reassessed if procedure scope changes.

SUPERVISOR TIPS

- **Ask specifically who completes the risk score — check for patient self-report specifically.** — This is a documented, specific

failure mode worth checking directly, not assuming.

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

EVIDENCE BASE

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

Train your team: AMB-19 · Plastic & Cosmetic Surgery on GMJ Academy →

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

19.2 Office-Based Anesthesia Follows Defined Safety Standards

NON-NEGOTIABLE

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

In plain terms: Anaesthesia in the office is delivered to the same standard as in a hospital — a qualified anaesthetist, full monitoring including capnography, and a plan for when things go wrong.

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

WHY THIS MATTERS

Deaths from office-based anaesthesia happen because the office is not a hospital: no anaesthetist, monitoring limited to pulse oximetry, no capnography to detect airway obstruction under sedation, no difficult airway kit, no plan for transfer. The patient under deep sedation for liposuction is as physiologically vulnerable as one in a hospital theatre — more so, if the monitoring is less. The standard is simple: the same person, equipment, and protocol you would find in a hospital operating room. If the office cannot provide that, it should not be doing the procedure.

WHAT GOOD LOOKS LIKE

- Anesthesia personnel meet hospital-equivalent qualification standards.
- Monitoring equipment is genuinely equivalent to a hospital operating room.
- A specific emergency transfer protocol exists with a named receiving facility.

COMMON FAILURE MODES

- Personnel qualifications are reduced relative to hospital standards, justified by the office setting.
- Monitoring equipment is a scaled-down version of what a hospital would use.
- No specific transfer protocol exists beyond a general assumption transfer would happen if needed.

WORKED EXAMPLE

IN PRACTICE

An office-based surgical suite where the surgeon administered sedation with a nurse monitoring.

BEFORE

The surgeon prescribed and the nurse gave propofol and ketamine. Monitoring was pulse oximetry and non-invasive blood pressure. No capnography. No anaesthetist. No difficult airway equipment. No written transfer plan. A patient became apnoeic during liposuction; the oximeter alarm was the first sign; she was bagged and recovered, but the event was not reported.

ACTION

An anaesthesia standard was adopted, matching the national hospital standard: an anaesthetist

(or, where legally permitted, a certified nurse anaesthetist) present and dedicated to the patient throughout; monitoring including continuous capnography for any sedation beyond minimal; pre-anaesthetic assessment documented; difficult airway kit and reversal agents present; a written transfer agreement with the nearest hospital; a monitored recovery area with discharge criteria. Sedation by the operating surgeon was prohibited.

AFTER

The Monitor reviewed the standard, observed a procedure with an anaesthetist and capnography, inspected the airway kit, and reviewed the hospital transfer agreement. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Who gives the anaesthesia in your office? Is that person also operating?
2. Is capnography used for every sedation? If not, that is the gap.
3. Adopt your national hospital anaesthesia standard verbatim.
4. Sign a transfer agreement with the nearest hospital.

The most common mistake: The operating surgeon directing sedation — they cannot watch the airway and the operation at once.

SELF-ASSESSMENT QUESTIONS

1. Is anesthesia administered by personnel with qualifications equivalent to a hospital operating room standard? — *The same qualification standard, not a reduced one for the office setting.*

Evidence: Anesthesia personnel qualification record

2. Is monitoring equipment equivalent to what a hospital operating room would use for the same procedure? — *Genuinely equivalent equipment, not a scaled-down version.*

Evidence: Monitoring equipment inventory

3. Is there a specific, defined emergency transfer protocol to a hospital, with a named receiving facility? — *A specific, real protocol and named facility, not a general assumption that transfer would happen*

if needed.

Evidence: Emergency transfer protocol document

COMMON REASONS FOR A PARTIAL ANSWER

- **Personnel qualifications are appropriate but monitoring equipment is older or less comprehensive than current hospital standard.** — Equipment standards, not just personnel qualifications, need to genuinely match hospital equivalence.
- **A transfer protocol exists but hasn't been tested or reviewed recently.** — An untested protocol may not translate smoothly into real action during an actual emergency.
- **The receiving facility was named some time ago but the relationship hasn't been reconfirmed as still active.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current anesthesia personnel qualifications and monitoring equipment against hospital-equivalent standards.
Week 2	Address any gap in personnel qualification or equipment equivalence.
Week 3	Establish or reconfirm a specific emergency transfer protocol with a named facility.
Ongoing	Periodically reconfirm the transfer relationship remains active.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Personnel qualification review	Reviews anesthesia personnel qualifications against hospital-equivalent standards.
OBSERVE	Monitoring equipment check	Physically confirms monitoring equipment is genuinely equivalent to hospital operating room standards.
DOCUMENT	Emergency transfer protocol review	Reviews the specific emergency transfer protocol and named receiving facility.

SUPERVISOR TIPS

- **Ask to see actual monitoring equipment and compare against hospital operating room standard.** — Direct physical comparison reveals whether equivalence is genuine, not assumed.
- **Ask for a real, recent example of the transfer protocol being used or tested.** — A real example, or its honest absence, reveals whether the protocol genuinely functions.

EVIDENCE BASE

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

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19.3 Patient Selection Excludes Those Outside Safe Office-Based Surgery Criteria

NON-NEGOTIABLE

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

In plain terms: Written rules say which patients cannot safely have surgery in the office — BMI above a limit, certain conditions, combined procedures over a time limit — and those rules are checked before booking.

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

WHY THIS MATTERS

An office surgical suite has no ICU, no blood bank, no on-call physician overnight. A patient with a BMI of 45, sleep apnoea, and poorly controlled diabetes, scheduled for six hours of combined procedures, is a patient who belongs in a hospital. Selection criteria — written, specific, checked at booking — keep the office for the patients it can safely serve. The criteria typically cover: BMI threshold, ASA class, specific conditions (sleep apnoea, cardiac disease, bleeding disorders), maximum total procedure duration, and maximum liposuction volume. A patient who does not meet them is referred to a hospital setting. No exceptions for a persuasive patient or a profitable case.

WHAT GOOD LOOKS LIKE

- Selection criteria are applied before scheduling, catching issues early.
- Criteria specifically address BMI, comorbidities, and duration limits.
- A real, documented example exists of a patient being declined or redirected.

COMMON FAILURE MODES

- Suitability is assessed only on the day of surgery, when declining is far harder.
- Criteria are general clinical judgement without specific, named factors.
- No example exists of the criteria ever actually resulting in a decline or redirection.

WORKED EXAMPLE

IN PRACTICE

An office-based plastic surgery practice with no written selection criteria.

BEFORE

The surgeon decided case by case. A patient with BMI 44 and untreated sleep apnoea had a combined abdominoplasty and breast reduction lasting seven hours in the office; she was transferred to hospital with respiratory failure in recovery. There were no written criteria to have prevented the booking.

ACTION

Selection criteria were written per national society guidance: BMI ≤ 35 , ASA I–II only, no untreated sleep apnoea, no significant cardiac or pulmonary

disease, combined procedure duration ≤ 4 hours, liposuction aspirate ≤ 4 litres. The criteria are checked and signed by the surgeon at the pre-operative consultation; booking staff cannot schedule a case without the signed sheet. Cases outside criteria are referred to the affiliated hospital.

AFTER

The Monitor reviewed the criteria, 20 booking records with signed selection sheets, and two cases referred to hospital because they exceeded criteria. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Write your selection criteria from national society guidance — BMI, ASA, conditions, duration, volume.
2. Add a selection checklist to the pre-operative consultation.
3. Make booking conditional on the signed checklist.
4. Have a hospital pathway for patients outside criteria.

The most common mistake: Deciding case by case — the decision is always harder when the patient is in front of you and wants the surgery.

SELF-ASSESSMENT QUESTIONS

- 1.** Are specific exclusion criteria for office-based surgery defined and applied before scheduling, not only assessed the day of surgery? —

Pre-scheduling assessment, catching an issue before the patient has already prepared and arrived.

Evidence: Pre-scheduling selection criteria document

- 2.** Do the criteria specifically address BMI thresholds, relevant comorbidities, and combined procedure duration limits? — *Specific, named factors, not a general clinical judgement standard.*

Evidence: N/A — tested directly

- 3.** Is there a real, documented example of a patient being declined or redirected to a hospital setting based on these criteria? — *A real example demonstrates the criteria have genuine teeth, not just theoretical existence.*

Evidence: Declined-case documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Criteria exist and are generally applied but aren't consistently checked before scheduling confirmation.** — The value of early assessment is lost if it happens after scheduling is already confirmed.
- **BMI and comorbidities are considered but combined procedure duration limits aren't specifically tracked.** — Combining multiple procedures can meaningfully extend total anesthesia time beyond any single procedure's individual risk profile.
- **The practice believes it would decline an unsuitable patient but has no real example to demonstrate this.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current patient selection timing against a genuine pre-scheduling standard.
Week 2	Establish specific, named exclusion criteria covering BMI, comorbidities, and duration limits.
Week 3	Build the criteria check into the scheduling process itself, before confirmation.
Ongoing	Document any case where criteria result in a decline or redirection.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Pre-scheduling criteria review	Reviews whether selection criteria are genuinely applied before scheduling, not only on the day of surgery.
DOCUMENT	Criteria specificity review	Reviews criteria for specific coverage of BMI, comorbidities, and duration limits.
DOCUMENT	Declined-case review	Reviews for a real, documented example of a patient declined or redirected based on the criteria.

SUPERVISOR TIPS

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

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

EVIDENCE BASE

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

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← **Ambulatory Clinic
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 18 — Allergy &
Immunotherapy**

**Standard 20 — Psychiatry &
Mental Health →**

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