

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 20

Standard 20 — Psychiatry & Mental Health

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

CRITERIA IN THIS STANDARD

20.1 — Suicide Risk Screening Uses a Validated Tool, Applied Consistently

20.2 — Psychiatric Medication Management Follows a Defined Interaction and Monitoring Protocol

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

20.1 Suicide Risk Screening Uses a Validated Tool, Applied Consistently

NON-NEGOTIABLE

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

In plain terms: Every patient is screened for suicide risk with a validated tool used exactly as designed, and anyone who screens positive gets a defined, evidence-based follow-up.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Most people who die by suicide have seen a healthcare provider in the preceding month. Many were never asked. A validated screen — Columbia Protocol, ASQ, PHQ-9 item 9 with follow-up — asks the question in a way that has been shown to identify risk without causing harm. 'Unmodified' matters: clinicians who soften the question, skip items, or use their own version lose the validation. A positive screen must lead somewhere: a same-day risk assessment, a safety plan, means restriction counselling, urgent referral if needed. A screen with no follow-up pathway is a question without an answer.

WHAT GOOD LOOKS LIKE

- A validated tool is used consistently, without informal modification.
- A positive screen triggers a defined, evidence-based follow-up assessment.
- Risk level is tied to a specific, written, individual mitigation plan.

COMMON FAILURE MODES

- Screening relies on informal clinical impression rather than a validated tool.
- A positive screen isn't followed by any defined next step.
- Risk is documented without any specific, individual mitigation plan attached.

WORKED EXAMPLE

IN PRACTICE

An outpatient psychiatry clinic seeing 200 patients a month.

BEFORE

Suicide risk was assessed by 'clinical judgment' during the interview. No standard tool. No documentation of the assessment in most records. A patient seen three days before his death had no documented suicide risk discussion. Staff said they 'always ask' but could not show it.

ACTION

The Columbia Suicide Severity Rating Scale screener was adopted for every visit,

administered verbatim by the clinician and documented. Positive screens trigger the full C-SSRS and a same-day risk formulation, a collaborative safety plan, means restriction counselling, and — by risk level — same-day psychiatrist review, crisis team referral, or emergency admission. A monthly audit checks screening completion and follow-up.

AFTER

The Monitor reviewed 40 records: all had documented C-SSRS screens; six positives each had a full assessment, safety plan, and risk-appropriate action. Audit compliance 97%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 20 records: is suicide risk documented with a named tool?
2. Adopt a validated screener and train every clinician to use it verbatim.
3. Write the follow-up pathway by risk level.
4. Audit monthly.

The most common mistake: Relying on 'clinical judgment' — clinicians consistently underestimate suicide risk in patients they know.

SELF-ASSESSMENT QUESTIONS

1. Is every patient screened using a validated tool, administered without informal changes to its wording? — *The tool exactly as validated, not adapted or shortened informally.*

Evidence: Screening tool documentation

2. Does a positive screen trigger a defined, evidence-based follow-up assessment, not just a note in the chart? — *A genuine, structured next step, not passive documentation alone.*

Evidence: Follow-up assessment protocol

3. Is the documented risk level tied to a specific, written mitigation plan for that patient? — *A real, individual plan, not a generic statement that risk was assessed.*

Evidence: Risk level and mitigation plan documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **The tool is used consistently but staff have informally shortened some questions to save time.** — Even small wording changes have been shown to affect a validated tool's accuracy.
- **Follow-up happens for clearly positive screens but is less consistent for borderline results.** — A consistent, defined threshold protects against inconsistent judgement calls.
- **A mitigation plan exists but isn't reviewed or updated at subsequent visits.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm the screening tool used is validated and administered without informal modification.
Week 2	Establish or reinforce a defined, evidence-based follow-up process for positive screens.
Week 3	Ensure every documented risk level is tied to a specific, individual mitigation plan.
Ongoing	Review and update mitigation plans at subsequent visits.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Screening tool review	Reviews the screening tool used for validation status and confirms it's administered without informal modification.
DOCUMENT	Follow-up protocol review	Reviews the defined follow-up process for patients who screen positive.
DOCUMENT	Mitigation plan review	Reviews documentation linking risk level to a specific, individual mitigation plan.

SUPERVISOR TIPS

- **Ask to see the exact screening tool used and confirm it matches the validated version, unmodified.** — Direct comparison is the only way to confirm the tool hasn't been informally altered.
- **Ask staff to describe the specific follow-up process for a positive screen.** — A specific, confident answer reveals a genuine, defined process rather than case-by-case judgement.

EVIDENCE BASE

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

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20.2 Psychiatric Medication Management Follows a Defined Interaction and Monitoring Protocol

NON-NEGOTIABLE

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

In plain terms: Psychiatric prescribing follows a defined process for checking drug interactions specific to psychotropic combinations, with required baseline and ongoing monitoring done and reviewed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Psychiatric medications interact dangerously: serotonin syndrome from SSRI plus MAOI or tramadol; QT prolongation from antipsychotic combinations; lithium toxicity from an added NSAID or diuretic; clozapine agranulocytosis without blood monitoring. The monitoring is specific and non-negotiable: lithium levels, renal and thyroid function; clozapine white cell counts; antipsychotic metabolic monitoring (weight, glucose, lipids); ECG for QT-prolonging drugs. A clinic without

a defined process — an interaction check at every prescription, a monitoring schedule per drug, a way to know when monitoring is overdue — will eventually have a preventable death.

WHAT GOOD LOOKS LIKE

- A specific process checks interactions for psychotropic combinations.
- Required baseline monitoring is genuinely completed before starting relevant medications.
- Ongoing monitoring is completed and reviewed at required intervals.

COMMON FAILURE MODES

- Interaction checking doesn't specifically address psychotropic combinations.
- Baseline monitoring is skipped or added only after a concern arises.
- Ongoing monitoring lapses or isn't reviewed even when technically completed.

WORKED EXAMPLE

IN PRACTICE

An outpatient psychiatry clinic with four prescribers and no shared monitoring system.

BEFORE

Interaction checking was by the prescriber's memory. Monitoring depended on the individual psychiatrist. The Coordinator found patients on lithium with no level for 14 months, patients on clozapine with lapsed blood monitoring, and a patient on three QT-prolonging drugs with no ECG. Nobody could say which patients were overdue.

ACTION	A prescribing process was implemented: an interaction check using a validated database documented at every new prescription or change; a monitoring schedule per high-risk drug (lithium, clozapine, antipsychotics, valproate) in a shared register with due dates; a monthly report of overdue monitoring reviewed by the clinical lead; ECG required before starting or combining QT-prolonging drugs. Prescriptions for patients with overdue monitoring are flagged and reviewed before renewal.
AFTER	The Monitor reviewed the monitoring register (no patient overdue), 20 prescription records with documented interaction checks, and the monthly overdue report showing resolution of all flagged cases. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every patient on lithium, clozapine, or valproate. When was their last monitoring?
2. Build a monitoring register with due dates.
3. Require a documented interaction check at every prescription.
4. Review overdue monitoring monthly and pause renewals until done.

The most common mistake: Having each psychiatrist manage their own monitoring — the patient who changes doctor falls through the gap.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined process for checking interactions specific to psychotropic medication combinations? — *A specific process for this medication class, not general interaction checking alone.*

Evidence: Psychotropic interaction checking protocol

2. Is required baseline monitoring completed before starting medications that specifically require it? — *Genuine baseline testing before starting, not added only if a concern later emerges.*

Evidence: Baseline monitoring record

3. Is ongoing monitoring completed and reviewed at the required intervals, not only at symptom-focused visits? — A defined, followed monitoring schedule, distinct from routine symptom check-ins.

Evidence: Ongoing monitoring schedule and review record

COMMON REASONS FOR A PARTIAL ANSWER

- **Interaction checking happens for new prescriptions but isn't rechecked when a second psychotropic medication is added later.** — Interaction risk applies at the point combinations actually occur, not only at initial prescribing.
- **Baseline monitoring is completed but results aren't reviewed before the medication is actually started.** — A completed test that isn't reviewed before prescribing doesn't provide the intended protection.
- **Ongoing monitoring is scheduled but appointments are sometimes missed without a specific follow-up process.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current interaction checking practice for psychotropic-specific coverage.
Week 2	Establish or verify required baseline monitoring completion before starting relevant medications.
Week 3	Establish a defined ongoing monitoring schedule with a specific follow-up process for missed appointments.
Ongoing	Audit monitoring completion and review against the required schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Interaction checking protocol review	Reviews the specific process for checking psychotropic medication interactions.
DOCUMENT	Baseline monitoring review	Reviews records confirming required baseline monitoring is completed before starting relevant medications.

Method	What	Detail
DOCUMENT	Ongoing monitoring review	Reviews adherence to the required ongoing monitoring schedule.

SUPERVISOR TIPS

- **Ask what specific baseline monitoring is required for a commonly prescribed psychotropic medication here.** — A specific, correct answer reveals genuine, current knowledge of monitoring requirements.
- **Ask what happens when a patient misses a required monitoring appointment.** — A specific, defined answer reveals whether this is genuinely tracked, not passively hoped for.

EVIDENCE BASE

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

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

NON-NEGOTIABLE

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

In plain terms: When a patient is in acute crisis, staff have an immediate, defined route to a named emergency psychiatric facility — tested and working, not a vague plan to 'get them to hospital.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A patient who discloses an active suicide plan in the waiting room cannot be given an appointment next week. A patient in acute psychosis cannot be sent home in a taxi. The clinic must have a pathway: who assesses, who decides, which facility receives, how the patient gets there safely, and what happens if the facility says no. The receiving facility is named, the phone number is known, the relationship is tested. Staff must know they have the authority to act without waiting. A pathway that exists on paper but has never been used will fail under pressure.

WHAT GOOD LOOKS LIKE

- A specific, defined escalation pathway exists for acute crisis.
- A specific, named receiving facility relationship is confirmed and active.
- All clinical staff, not just the most senior, know the pathway confidently.

COMMON FAILURE MODES

- No specific pathway exists beyond general awareness that emergency services could be contacted.
- No specific receiving facility is named, only a general assumption.
- Only the most senior staff member present is confident in the escalation process.

WORKED EXAMPLE

IN PRACTICE

An outpatient psychiatry clinic 30 minutes from the nearest psychiatric inpatient unit.

BEFORE

Crisis management was ad hoc. A patient in acute crisis was told to 'go to the emergency department' and left alone; he did not go. Staff did not know who to call at the inpatient unit. The clinic had no relationship with the crisis team. No safe transport arrangement existed.

ACTION

A crisis pathway was written: immediate clinician assessment; risk-level decision; for high risk — patient not left alone, direct phone line to the inpatient unit's admissions doctor (agreed and tested), ambulance or crisis team transport arranged, handover documented; if the unit declines, escalation to the on-call consultant. The pathway is posted. A quarterly test call is made. Reception staff are trained to recognise crisis presentations and alert a clinician immediately.

AFTER

The Monitor reviewed the pathway, the test call log, and three crisis events managed per pathway with documented handovers. Interviewed a receptionist who described the alert process. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Phone your nearest psychiatric unit now: who answers, and would they take a patient from you today?
2. Write a crisis pathway with a named receiving facility and a direct number.
3. Arrange safe transport — ambulance or crisis team, never a taxi alone.
4. Train reception to recognise crisis and alert immediately.

The most common mistake: Telling a patient in crisis to go to the emergency department and assuming they will.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, defined escalation pathway for a patient in acute crisis, not general awareness that help exists? — *A specific, known pathway, not improvisation in the moment.*

Evidence: Crisis escalation protocol document

2. Is there a specific, named receiving facility for emergency psychiatric care? — *A specific facility and relationship, not a general assumption somewhere would take the patient.*

Evidence: Named receiving facility documentation

3. Do all clinical staff, not only the most senior, know the specific escalation steps confidently? — *Genuine, distributed readiness, not knowledge held only by the most experienced person present.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The pathway is well understood by the primary psychiatrist but less consistently by other clinical staff.** — A crisis can be first recognised by any staff member present, not only the psychiatrist.
- **A receiving facility relationship exists but hasn't been reconfirmed as active recently.** — Relationships can lapse without either party actively noticing.
- **The pathway is known but has never been rehearsed as an actual drill.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current crisis escalation practice for a specific, defined pathway.
Week 2	Confirm or establish a specific, named receiving facility relationship.
Week 3	Brief all clinical staff, not only senior staff, on the specific escalation steps.
Ongoing	Periodically reconfirm the receiving facility relationship remains active.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Escalation pathway review	Reviews the specific, defined escalation pathway for completeness.
DOCUMENT	Receiving facility review	Reviews the specific, named receiving facility relationship for emergency psychiatric care.
ASK	Staff readiness interview	Asks a range of staff, not only the most senior, to describe the escalation pathway.

SUPERVISOR TIPS

- **Ask a non-senior staff member to describe the escalation pathway.** — This reveals whether readiness is genuinely distributed, not concentrated in one person.
- **Ask for a real, recent example of the pathway being used, or a genuine drill.** — A real example, or its honest absence, reveals whether this pathway genuinely functions under real conditions.

EVIDENCE BASE

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

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← **Ambulatory Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 19 — Plastic & Cosmetic Surgery**

Standard 21 — Narcology & Addiction Treatment →

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ASF STANDARDS · AMBULATORY CLINIC · STANDARD 21

Standard 21 — Narcology & Addiction Treatment

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

CRITERIA IN THIS STANDARD

- 21.1 — Controlled Substance Handling Follows a Defined Diversion Control Plan
- 21.2 — Withdrawal Management Uses a Validated Assessment Scale, Not Clinical Impression Alone
- 21.3 — Urine Drug Screening Chain of Custody Prevents Tampering

21.1 Controlled Substance Handling Follows a Defined Diversion Control Plan

NON-NEGOTIABLE

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

In plain terms: Methadone, buprenorphine, and other controlled medicines in addiction treatment are stored, dispensed, and taken home under a written plan that prevents diversion — with records that account for every dose.

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

WHY THIS MATTERS

Opioid agonist treatment saves lives — and its medicines have street value. Diversion harms the patient who is not taking their dose, the person who buys it, and the programme whose credibility depends on control. A diversion control plan specifies: secure storage with restricted access and a register; supervised consumption for new and unstable patients; take-home eligibility criteria; random callbacks for take-home patients to count remaining doses; urine testing; reconciliation of stock against dispensing daily. Any discrepancy is investigated. A programme without this is a supply.

WHAT GOOD LOOKS LIKE

- A specific, written diversion control plan covers storage, dispensing, and take-home provision.
- Take-home packaging is specifically identifiable and secure.
- Patients receive genuine, documented education on safe storage and transport.

COMMON FAILURE MODES

- No specific written plan exists beyond general good practice.
- Take-home packaging isn't specifically identifiable or secure.
- Patient education on storage and transport is assumed rather than genuinely provided.

WORKED EXAMPLE

IN PRACTICE

An addiction treatment clinic with 150 patients on methadone and buprenorphine.

BEFORE

Methadone was stored in a locked cupboard with one key held by whoever was on duty. The dispensing record was a notebook. Stock was not reconciled. Take-home doses were given by clinician discretion without written criteria. Two patients were found to be selling take-home doses; the clinic could not account for a 400 ml discrepancy in the previous quarter.

ACTION	A diversion control plan was written: controlled drug safe with dual-key access and a signed register; daily stock reconciliation with any discrepancy reported to the medical director within 24 hours; supervised consumption for the first 12 weeks and for any patient with positive urine screens; written take-home criteria (stability, negative screens, safe storage confirmed); random callbacks for 10% of take-home patients monthly; a dispensing record with two signatures per dose.
AFTER	The Monitor inspected the safe and register, reviewed three months of daily reconciliations with no unexplained discrepancy, reviewed take-home criteria applied in 15 records, and callback records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Reconcile your controlled drug stock today against your dispensing records. Does it balance?
2. Install dual-key access and a signed register.
3. Write take-home criteria and supervised consumption rules.
4. Start random callbacks.

The most common mistake: Storing methadone in a cupboard with a shared key and a notebook — that is not control, it is trust.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, written diversion control plan covering storage, dispensing, and take-home provision? — *A specific, documented plan, not general good practice assumed to be sufficient.*

Evidence: Diversion control plan document

2. Is take-home medication packaged and labeled in a way specifically designed to identify it and deter diversion? — *Specific, identifiable packaging, not standard containers without distinguishing features.*

Evidence: Take-home packaging protocol

3. Do patients receiving take-home medication receive specific education on safe storage and transport, including household safety? — *Genuine, documented education, not assumed common sense.*

Evidence: Patient education documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Storage security is strong but dispensing records aren't consistently reconciled against inventory.** — Diversion can occur at the dispensing stage even when storage itself is secure.
- **Take-home packaging is used but doesn't consistently include identifying information.** — Identifiable packaging is specifically what allows recovery or accountability if diversion is suspected.
- **Education happens for new patients but isn't reinforced for those on long-term take-home regimens.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current controlled substance handling against a specific, written diversion control plan standard.
Week 2	Establish or strengthen identifiable, secure take-home packaging.
Week 3	Establish genuine, documented patient education on safe storage and transport.
Ongoing	Reconcile dispensing records against inventory regularly.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Diversion control plan review	Reviews the written diversion control plan for specificity and completeness.
OBSERVE	Take-home packaging check	Confirms take-home medication packaging is specifically identifiable and secure.
DOCUMENT	Patient education review	Reviews documentation of specific patient education on safe storage and transport.

SUPERVISOR TIPS

- **Ask for the actual written diversion control plan, not a general description of careful handling.** — A specific, written document is the real evidence of a genuine plan.
- **Ask a patient receiving take-home medication what storage guidance they were given.** — This reveals whether education is genuine practice, not just assumed to have happened.

EVIDENCE BASE

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

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

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

NON-NEGOTIABLE

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

In plain terms: Withdrawal severity is measured with a validated scale (COWS for opioids, CIWA-Ar for alcohol) at set intervals, and the score — not the clinician's impression — drives treatment.

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

WHY THIS MATTERS

Alcohol withdrawal untreated progresses to seizures and delirium tremens, which kills. Opioid withdrawal undertreated drives patients back to using. Clinical impression underestimates both: the patient who 'seems fine' is sweating and tremulous on examination. Validated scales — CIWA-Ar for alcohol, COWS for opioids — give a number that maps to a treatment: below X, observe; X to Y, symptomatic medication; above Y, start the protocol. Scored at defined intervals, the trend shows whether treatment is working. A programme that manages withdrawal by impression will miss the patient heading for a seizure.

WHAT GOOD LOOKS LIKE

- A validated scale is used consistently for every applicable patient.
- Assessment happens at defined, scheduled intervals.
- Management decisions are genuinely and documentably linked to the score.

COMMON FAILURE MODES

- Withdrawal severity is estimated from clinical impression without a structured tool.
- Assessment happens only reactively, when a concern arises.
- Scores are recorded but don't genuinely drive the management decision made.

WORKED EXAMPLE

IN PRACTICE

An outpatient addiction clinic managing alcohol and opioid withdrawal.

BEFORE

Withdrawal was assessed by asking the patient how they felt. Medication was given 'as needed.' A patient in alcohol withdrawal was sent home as 'mild' and had a seizure that night. No scale was used; no score was documented.

ACTION

CIWA-Ar and COWS were adopted, administered by trained nurses at every visit and at defined intervals during medically managed withdrawal (e.g. CIWA every 4 hours for outpatient alcohol detox with a home carer). Treatment protocols are triggered by score: CIWA ≥ 10 → benzodiazepine per protocol; ≥ 20 or seizure

history → inpatient referral. Scores are charted to show trend. Nurses completed a half-day training on scale administration.

AFTER

The Monitor reviewed 20 withdrawal management records with scored assessments at protocol intervals and score-driven treatment; two showed inpatient referral for high scores. Training records complete. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten withdrawal records: is a validated scale scored? How often?
2. Adopt CIWA-Ar and COWS and train nurses to administer them.
3. Write treatment thresholds by score.
4. Chart scores to show trend.

The most common mistake: Managing alcohol withdrawal on how the patient looks — the seizure comes when they looked fine an hour ago.

SELF-ASSESSMENT QUESTIONS

1. Is a validated, standardised withdrawal assessment scale used consistently, not clinical impression alone? — *A specific, validated tool, applied the same way every time.*

Evidence: Withdrawal assessment scale documentation

2. Is the scale applied at defined intervals appropriate to the withdrawal risk, not only when a concern happens to arise? — *A specific, scheduled interval, not reactive assessment alone.*

Evidence: Assessment interval protocol

3. Does the scale result actually guide the management decision, not just get recorded alongside a separately made clinical decision? — *Genuine, documented linkage between score and decision, not parallel, disconnected processes.*

Evidence: Score-to-decision linkage record

COMMON REASONS FOR A PARTIAL ANSWER

- **The scale is used consistently during standard hours but less consistently during off-hours coverage.** — Withdrawal risk doesn't diminish outside standard operating hours.
- **Assessment intervals are followed initially but relax as a patient's condition appears to stabilise.** — Early stabilisation doesn't eliminate the value of continued, consistent monitoring.
- **The score is calculated correctly but the specific threshold for changing management isn't clearly defined.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current withdrawal assessment practice for validated scale use versus clinical impression alone.
Week 2	Establish or reinforce a defined assessment interval schedule.
Week 3	Define clear thresholds linking specific scores to specific management decisions.
Ongoing	Audit consistency of scale use across all coverage periods, including off-hours.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Assessment scale review	Reviews the specific validated scale used and confirms consistent application.
DOCUMENT	Assessment interval review	Reviews the defined interval schedule for withdrawal assessment.
DOCUMENT	Score-to-decision review	Reviews whether management decisions are genuinely linked to the assessment score.

SUPERVISOR TIPS

- **Ask staff working off-hours or covering shifts specifically about assessment practice.** — This is where consistency most commonly relaxes relative to standard hours.
- **Ask for a specific example of a score change leading to a specific management change.** — A real example reveals whether the score genuinely drives decisions, not just gets recorded.

EVIDENCE BASE

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

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21.3 Urine Drug Screening Chain of Custody Prevents Tampering CORE

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

In plain terms: Urine drug tests are collected and handled in a way that stops substitution and tampering — temperature checked, observed when necessary, sealed and tracked — so results can be trusted.

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

WHY THIS MATTERS

A urine drug screen guides take-home decisions, treatment adjustments, and sometimes legal consequences. A sample that was substituted with a friend's urine, diluted with tap water, or swapped in transit is worse than no sample: it produces a confident wrong answer. Chain of custody means: identity verified; temperature checked within four minutes (32–38°C); observed collection where clinically indicated and with dignity safeguards; sample sealed in the patient's presence and initialled; a log from collection to result. This protects the patient from false accusations as much as it protects the programme from manipulation.

WHAT GOOD LOOKS LIKE

- Specimen temperature is verified and documented immediately after collection.
- Direct observation follows a specific, defined standard, applied consistently.
- Chain of custody is genuinely unbroken and documented, with any gap specifically flagged.

COMMON FAILURE MODES

- Temperature verification doesn't happen or isn't documented.
- Direct observation is applied inconsistently without a clear standard.
- Chain of custody has undocumented gaps or is assumed intact without verification.

WORKED EXAMPLE

IN PRACTICE

An addiction clinic using urine screens to decide take-home eligibility.

BEFORE

Patients were given a cup and pointed to the toilet. No temperature check. No observation. Samples sat unlabelled on a bench until batched. A patient obtained take-home doses for a year on consistently clean screens that were later found to be his partner's urine.

ACTION

A chain-of-custody procedure was written: two-identifier check; temperature strip read within four minutes with out-of-range samples rejected; observed collection for patients with prior tampering, new admissions, or clinical concern, by a same-gender staff member with a written dignity protocol; sample sealed and initialled by patient and staff at the point of collection; a custody log from collection to result. Adulteration testing added to the lab panel.

AFTER

The Monitor observed a collection following the procedure, reviewed the custody log for 50 samples, and reviewed the observed-collection protocol. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch a urine collection. Is temperature checked? Is the sample sealed in front of the patient?
2. Buy temperature strips and reject out-of-range samples.
3. Write criteria for observed collection with a dignity protocol.
4. Start a custody log.

The most common mistake: Trusting a clean screen without knowing the sample was the patient's — a clean screen from someone else's bladder is a false negative.

SELF-ASSESSMENT QUESTIONS

1. Is specimen temperature verified immediately after collection, as a specific, documented step? — *A specific, documented check, not assumed from general collection procedure.*

Evidence: Temperature verification record

2. Is direct observation used where clinically indicated, following a specific, defined standard for when it applies? — *A specific standard for when observation is used, not inconsistent, ad hoc application.*

Evidence: Direct observation policy

3. Is chain of custody maintained and documented from collection through to result, with any break specifically flagged? — *A genuinely unbroken, documented chain, with any gap specifically identified, not assumed intact.*

Evidence: Chain of custody documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Temperature verification happens but isn't consistently documented in the specimen record.** — An undocumented check is difficult to distinguish from a check that didn't happen.
- **Direct observation criteria exist but aren't consistently applied by all staff collecting specimens.** — A standard needs consistent application across everyone performing collection to provide real protection.
- **Chain of custody documentation exists but has occasional gaps during transport to an external lab.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current specimen collection practice for temperature verification and documentation.
Week 2	Establish or reinforce a specific, consistently applied direct observation standard.
Week 3	Close any gap in chain-of-custody documentation, particularly during external transport.
Ongoing	Audit chain-of-custody documentation for completeness periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Temperature verification review	Reviews records confirming specimen temperature is verified immediately after collection.
DOCUMENT	Direct observation policy review	Reviews the specific standard for when direct observation is clinically indicated and applied.
DOCUMENT	Chain of custody review	Reviews documentation for a genuinely unbroken chain of custody from collection to result.

SUPERVISOR TIPS

- **Ask to see the actual temperature verification and chain-of-custody documentation for a recent specimen.** — Specific, dated records are the only real evidence of a genuinely functioning process.
- **Ask staff the specific criteria for when direct observation is used.** — A specific, consistent answer reveals a genuine standard rather than inconsistent individual judgement.

EVIDENCE BASE

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

Train your team: AMB-21 · Narcology & Addiction 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 20 — Psychiatry
& Mental Health**

**Standard 22 —
Gastroenterology &
Endoscopy →**

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Standard 22 — Gastroenterology & Endoscopy

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

CRITERIA IN THIS STANDARD

- 22.1 — Endoscope Reprocessing Follows the Multisociety Guideline, With Documented Staff Competency
- 22.2 — Procedural Sedation Monitoring Follows Defined Standards
- 22.3 — Biopsy and Polyp Specimens Are Tracked to a Confirmed Pathology Result

22.1 Endoscope Reprocessing Follows the Multisociety Guideline, With Documented Staff Competency

NON-NEGOTIABLE

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

In plain terms: Flexible endoscopes are cleaned and disinfected following the full multisociety guideline — manual cleaning first, the manufacturer’s exact instructions for each model, every step recorded — by staff whose competency is documented.

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

WHY THIS MATTERS

Endoscopes have been the source of hospital outbreaks of carbapenem-resistant bacteria, hepatitis, and pseudomonas. They are complex instruments with long, narrow channels that must be brushed and flushed before high-level disinfection can work; a scope that goes into the disinfectant without proper manual cleaning comes out contaminated. The multisociety guideline (ASGE/SGNA/AORN/APIC) specifies each step; manufacturer instructions specify the details for each scope model. Documentation traces every scope through every reprocessing cycle to every patient. Competency means the reprocessing staff have been trained on the specific scopes and assessed as able — not that they have been doing it for years.

WHAT GOOD LOOKS LIKE

- The written policy matches the current multisociety guideline, including model-specific instructions.
- Staff competency is specifically assessed and documented before independent practice.
- Every reprocessing step is documented, creating a genuine, traceable record.

COMMON FAILURE MODES

- The policy is outdated or doesn't reflect model-specific manufacturer instructions.
- Staff perform reprocessing without documented, assessed competency.
- Reprocessing documentation is partial or assumed rather than genuinely complete.

WORKED EXAMPLE

IN PRACTICE

An endoscopy unit with six gastroscopes and four colonoscopes processed in an automated reprocessor.

BEFORE

Manual cleaning was 'a quick brush' before the reprocessor. Channel brushing was inconsistent. No reprocessing log linked scope to patient. Staff had learned from a colleague; no competency assessment existed. Manufacturer instructions were in a drawer, unread. A cluster of post-

	procedure infections had been noted but not investigated.
ACTION	The multisociety guideline was adopted in full. Manufacturer instructions for each scope model were laminated at the reprocessing station. A step-by-step reprocessing record is completed per scope per cycle, including manual cleaning with brush size per channel, leak test, reprocessor cycle printout, and drying, and links the scope serial number to the patient it is next used on. All reprocessing staff completed a competency assessment on each scope model, repeated annually. Quarterly surveillance cultures of scopes.
AFTER	The Monitor observed a full reprocessing cycle following the guideline, reviewed two months of per-scope records linking to patients, reviewed competency records, and reviewed surveillance cultures (all negative). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch a scope being reprocessed. Is every channel brushed?
Is a leak test done?
2. Find the manufacturer's instructions for each scope. Post them at the station.
3. Start a per-scope, per-cycle record linked to patient.
4. Assess every reprocessor's competency on every scope model.

The most common mistake: Relying on the automated reprocessor — it cannot disinfect a scope that was not properly cleaned first.

SELF-ASSESSMENT QUESTIONS

1. Does reprocessing follow a written policy matching the current multisociety guideline, including model-specific manufacturer instructions? — *A specific, current, written policy, not general infection-*

control practice assumed to be sufficient.

Evidence: Reprocessing policy document

2. Is staff competency specifically assessed and documented before they perform reprocessing independently? — *Assessed competency before independent practice, not assumed from general training.*

Evidence: Staff competency assessment record

3. Is every reprocessing step documented for every instrument, creating a genuine, traceable record? — *Complete, traceable documentation, not partial or assumed record-keeping.*

Evidence: Reprocessing step documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Competency was assessed at hiring but hasn't been reassessed as new endoscope models were introduced.** — Model-specific competency needs to reflect the actual equipment currently in use, not only equipment used at initial training.
- **Documentation is complete for the disinfection step but less consistent for the initial cleaning step.** — Cleaning before disinfection is itself a critical, distinct step the guideline specifically requires be documented.
- **The policy exists but wasn't updated when the current multisociety guideline was last revised.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current reprocessing policy against the current multisociety guideline in full.
Week 2	Establish or verify documented competency assessment for every staff member, specific to equipment currently in use.
Week 3	Confirm complete, traceable documentation exists for every reprocessing step.
Ongoing	Reassess competency whenever new endoscope models are introduced.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Reprocessing policy review	Reviews the written reprocessing policy against the current multisociety guideline.
DOCUMENT	Staff competency review	Reviews competency assessment records for every staff member performing reprocessing.
DOCUMENT	Step documentation review	Reviews reprocessing records for complete, traceable documentation of every step.

SUPERVISOR TIPS

- **Ask for the actual competency assessment record for a specific staff member.** — A specific, documented record is the only real evidence competency was genuinely verified, not assumed.
- **Ask whether the policy has been reviewed since the guideline was last revised.** — This reveals whether the facility's practice stays genuinely current, not just historically compliant.

EVIDENCE BASE

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

[ASF training courses on GMJ Academy →](#)

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

22.2 Procedural Sedation Monitoring Follows Defined Standards

NON-NEGOTIABLE

Patients receiving procedural sedation for endoscopy are monitored using continuous pulse oximetry and capnography, with vital signs recorded at defined intervals

and specific, defined discharge criteria met before release — not monitored informally or released based on general appearance alone.

In plain terms: Patients sedated for endoscopy are monitored with continuous pulse oximetry and capnography, vital signs recorded at set intervals, and discharged only when they meet written criteria.

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

WHY THIS MATTERS

Sedation for endoscopy causes respiratory depression that pulse oximetry detects late — oxygen saturation falls only after the patient has already stopped breathing adequately for a minute or more. Capnography detects it immediately. Deaths during endoscopy sedation are almost always from unrecognised hypoventilation. Monitoring means: continuous oximetry and capnography from sedation to recovery; blood pressure and pulse at defined intervals; a dedicated person watching the patient, not the screen; and discharge only when written criteria — awake, oriented, stable vitals, able to walk, accompanied — are met and documented.

WHAT GOOD LOOKS LIKE

- Continuous pulse oximetry and capnography are used for every sedated patient.
- Vital signs are recorded at defined intervals throughout procedure and recovery.
- Specific, defined discharge criteria are met and documented before release.

COMMON FAILURE MODES

- Monitoring is periodic or informal rather than continuous and objective.
- Vital signs are recorded only at the start and end, with gaps during the procedure.
- Discharge is based on general appearance rather than specific, documented criteria.

WORKED EXAMPLE

IN PRACTICE

An endoscopy unit performing 3,000 sedated procedures a year.

BEFORE	Monitoring was pulse oximetry only, watched by the endoscopy nurse who was also assisting with the procedure. No capnography. Discharge was 'when awake enough.' A patient became severely hypoxic during a prolonged colonoscopy; the oximeter alarmed after 90 seconds of apnoea. Another was discharged, fell in the car park, and fractured her wrist.
ACTION	Capnography was added to every sedation. A dedicated monitoring nurse (not the endoscopy assistant) watches the patient and records vital signs every five minutes during the procedure and every 15 minutes in recovery. Written discharge criteria (modified Aldrete score ≥ 9 , able to walk unaided, oral fluids tolerated, responsible adult present) are documented and signed. Staff completed sedation monitoring training.
AFTER	The Monitor observed two procedures with capnography and a dedicated monitor, reviewed 30 records with interval vital signs and completed discharge criteria, and training records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Is capnography used for every sedation? If not, that is the gap.
2. Assign a dedicated monitoring nurse separate from the procedure assistant.
3. Write discharge criteria and require documentation against them.
4. Record vital signs at defined intervals on a chart.

The most common mistake: Relying on pulse oximetry alone — by the time saturation falls, the patient has been hypoventilating for a minute.

SELF-ASSESSMENT QUESTIONS

1. Is continuous pulse oximetry and capnography used for every patient receiving procedural sedation? — *Continuous, objective monitoring, not periodic spot-checking.*

Evidence: Sedation monitoring protocol

2. Are vital signs recorded at defined intervals throughout the procedure and recovery, not only at the start and end? — *Consistent, scheduled recording throughout, not concentrated at the edges.*

Evidence: Vital signs recording log

3. Are specific, defined discharge criteria met and documented before a patient is released, not judged from general appearance? — *A specific, validated criteria set, not a subjective impression the patient seems ready.*

Evidence: Discharge criteria documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Pulse oximetry is used consistently but capnography is used only for higher-sedation-level cases.** — Capnography detects respiratory compromise earlier than pulse oximetry alone, at any sedation level.
- **Vital signs recording is thorough during the procedure but less consistent during recovery.** — Sedation-related complications can develop during recovery, not only during the procedure itself.
- **Discharge criteria exist but aren't consistently documented as having been checked for each patient.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current sedation monitoring practice for continuous, objective monitoring use.
Week 2	Extend capnography use to all sedation levels if not already standard.
Week 3	Establish consistent vital signs recording throughout both procedure and recovery.
Ongoing	Audit discharge criteria documentation for every sedated patient.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Monitoring practice observation	Observes actual sedation monitoring for continuous pulse oximetry and capnography use.
DOCUMENT	Vital signs recording review	Reviews recording logs for defined-interval consistency throughout procedure and recovery.
DOCUMENT	Discharge criteria review	Reviews documentation confirming specific discharge criteria were met before release.

SUPERVISOR TIPS

- **Observe actual sedation monitoring during a procedure if timing allows.** — Direct observation reveals whether monitoring is genuinely continuous, not just described as such.
- **Ask for the specific discharge criteria used and check documentation for a recent patient.** — A specific, checkable record is the real evidence discharge decisions are criteria-based, not impression-based.

EVIDENCE BASE

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

[ASF training courses on GMJ Academy →](#)

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

22.3 Biopsy and Polyp Specimens Are Tracked to a Confirmed Pathology Result

NON-NEGOTIABLE

Every biopsy or removed polyp specimen is tracked from collection through to a confirmed, communicated pathology result, with a specific, named process ensuring no

specimen result goes unreviewed or unreported to the patient — distinct from, and more specifically tracked than, general test results.

In plain terms: Every biopsy and polyp is tracked from the endoscopy room to a confirmed pathology result and to the patient being told — with a named person responsible and no specimen unaccounted for.

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

WHY THIS MATTERS

A colonoscopy polyp that is cancer, whose result sits unread or whose patient is never contacted, is a curable cancer allowed to become incurable. Endoscopy units generate many specimens; most are benign; the tracking system relaxes; the one that matters is missed. The system must log every specimen at the point of collection, confirm receipt by the lab, flag results not returned by the expected date, require clinician review within a defined time, and confirm the patient has been informed — with a named owner who checks the log weekly. This is the endoscopy version of dermatology 17.1 and the same principle applies.

WHAT GOOD LOOKS LIKE

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

COMMON FAILURE MODES

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

WORKED EXAMPLE

IN PRACTICE

An endoscopy unit taking 200 specimens a month.

BEFORE	Specimens were labelled and sent. Results returned to the referring doctor's tray. No log. When the Coordinator matched lab records to patient notes, six results in three months had never been reviewed; one showed adenocarcinoma in a polyp; the patient was contacted four months late.
ACTION	A specimen log was created: patient, date, site, number of pots, sent date, lab receipt confirmation, result date, reviewed date, patient informed date. The endoscopy nurse manager owns it and reviews it weekly. Results not received in 10 days are chased. Results not reviewed in 48 hours of receipt are escalated. Malignant results trigger same-day patient contact and MDT referral. Monthly reconciliation of lab specimen count against the log.
AFTER	The Monitor reviewed the log for four months: 800 specimens, all reaching 'patient informed'; median time from result to patient contact 4 days; three malignancies referred within 24 hours. Monthly reconciliation matched. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Get the lab's list of specimens from your unit last month. Match each to a reviewed result and an informed patient.
2. Start a specimen log with every stage dated.
3. Name an owner and review weekly.
4. Reconcile against lab counts monthly.

The most common mistake: Sending results to the referring doctor's tray and assuming they will be actioned — trays are where results go to be forgotten.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, named tracking process for biopsy and polyp specimens, distinct from general test result tracking? — *A dedicated*

process specifically for these specimens, given the distinct severity risk.

Evidence: Specimen tracking log

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

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 specimens collected by the primary gastroenterologist but not consistently for those collected by covering staff.** — Every specimen carries the same real risk, regardless of who performed the procedure.
- **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 specimen tracking practice for a specific, dedicated process.
Week 2	Establish a tracking log covering every specimen from collection to confirmed, communicated result.
Week 3	Build a mechanism to actively surface any specimen without a received result.
Ongoing	Review the tracking log on a regular schedule for gaps.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **Ask for the actual tracking log and pick a specific, older specimen to trace through it.** — Tracing a real, specific case reveals whether the system genuinely works, not just whether it exists.
- **Ask specifically about specimens collected during procedures performed by covering staff.** — This is where tracking most commonly shows real gaps.

EVIDENCE BASE

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

[ASF training courses on GMJ Academy →](#)

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

← **Ambulatory Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 21 — Narcology & Addiction Treatment**

**Standard 23 — Pediatric
Ambulatory Care →**

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ASF STANDARDS · AMBULATORY CLINIC · STANDARD 23

Standard 23 — Pediatric Ambulatory Care

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

CRITERIA IN THIS STANDARD

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

23.2 — Consent and Communication Are Structured for the Actual Decision-Maker

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

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

NON-NEGOTIABLE

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

In plain terms: Every child's medication dose is calculated from a weight measured today on a calibrated scale — not estimated, not parent-reported, not from last visit — and the calculation is checked by a second person.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Children's doses are by weight. A dose based on a weight that is wrong by 30% is a dose that is wrong by 30% — and children have less reserve for error. Parents estimate badly; a weight from six months ago is obsolete in a growing child; a weight in pounds entered as kilograms is a 2.2-fold overdose. Tenfold errors from decimal point mistakes are the most common serious paediatric medication error. The defences are: weigh the child today, in kilograms, on a calibrated scale; record it; calculate the dose from it; have a second person independently recalculate; compare.

WHAT GOOD LOOKS LIKE

- Every weight-based dose uses a weight measured at the current visit.
- Dose calculations are genuinely, independently verified by a second trained person.
- A specific, known response exists for a dose falling outside the expected range.

COMMON FAILURE MODES

- Weight is estimated, parent-reported, or carried over from a prior visit without remeasurement.
- Verification, if it happens, isn't genuinely independent.
- No specific process exists for an out-of-range calculated dose.

WORKED EXAMPLE

IN PRACTICE

A paediatric ambulatory clinic seeing 80 children a day.

BEFORE

Weight was asked of the parent or taken from the last visit. Doses were calculated by the prescriber alone. A 14 kg child was prescribed amoxicillin for a 24 kg weight the mother had given from memory; another received a tenfold paracetamol dose from a decimal error nobody checked.

ACTION

The rule was written: every child is weighed on a calibrated scale at every visit before any prescription; the weight in kg is recorded on the

prescription; the dose calculation ($\text{mg/kg} \times \text{kg}$) is shown on the prescription; a second staff member independently recalculates and initials before dispensing or administration. Scales are calibrated quarterly. Pharmacy rejects any prescription without a weight and calculation.

AFTER

The Monitor reviewed 30 prescriptions: all had same-day weights, shown calculations, and second-person initials. Observed a child weighed and dose double-checked. Calibration certificate on file. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 20 paediatric prescriptions: is the weight recorded? Is it from today?
2. Weigh every child at every visit before prescribing.
3. Show the calculation on the prescription.
4. Require a second person to recalculate and initial.

The most common mistake: Accepting the parent's estimate of the child's weight — parents are wrong by 20–30% routinely.

SELF-ASSESSMENT QUESTIONS

1. Is every weight-based dose calculated from a weight measured at this visit, not estimated or carried over from a prior visit? — *A current, actually measured weight, not an estimate or an assumption it hasn't changed.*

Evidence: Weight measurement record

2. Is the dose calculation independently verified by a second trained person before administration? — *Genuine, independent verification, not the same person confirming their own calculation.*

Evidence: Independent dose verification record

3. Is there a specific, defined process if the calculated dose falls outside an expected range for the child's age or weight? — *A specific, known response, not proceeding regardless because the calculation was technically completed.*

Evidence: Out-of-range dose response protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Weight is measured at every visit but independent verification is inconsistent for lower-risk medications.** — The weight-based calculation itself carries the same real risk regardless of the specific medication's perceived risk level.
- **Verification happens but the second person reviews the same source information rather than calculating independently.** — Genuine independence requires a separate calculation, not confirmation of the same numbers already entered.
- **An out-of-range threshold exists but isn't consistently applied by all staff.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current weight measurement practice for consistency at every visit.
Week 2	Establish genuine, independent second-person dose verification for all weight-based medications.
Week 3	Define a specific out-of-range response threshold and process.
Ongoing	Audit verification genuineness and out-of-range response adherence periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Weight measurement review	Reviews records confirming weight-based doses use a weight measured at the current visit.
OBSERVE	Independent verification observation	Observes an actual dose calculation for genuine, independent second-person verification.
ASK	Out-of-range response interview	Asks staff what happens when a calculated dose falls outside the expected range.

SUPERVISOR TIPS

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

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

EVIDENCE BASE

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

ASF training courses on GMJ Academy →

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

23.2 Consent and Communication Are Structured for the Actual Decision-Maker

NON-NEGOTIABLE

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

In plain terms: Consent and key discussions are held with the child's actual legal decision-maker — confirmed to be the right person — and the child is included in a way that fits their age.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The adult who brought the child may be a grandparent, a nanny, an older sibling, or a parent without legal custody. Consent from any of them is not valid. The clinic must confirm who holds parental responsibility and speak to that person — in person, or by phone if

necessary — before any significant treatment. At the same time, the child is not a bystander: a six-year-old can be told what will happen in words they understand; a fourteen-year-old may have the maturity to be involved in decisions and, in some jurisdictions, to consent independently. Age-appropriate communication is both ethical and practical: a child who understands cooperates.

WHAT GOOD LOOKS LIKE

- Decision-making authority is specifically verified for each child.
- A specific, known process exists for non-parent accompanying adults.
- Age-appropriate communication to the child happens as a genuine, distinct step.

COMMON FAILURE MODES

- Decision-making authority is assumed from whoever accompanies the child.
- No specific process exists for situations involving a non-parent adult.
- The child is excluded from all communication, treated only as the subject of parental consent.

WORKED EXAMPLE

IN PRACTICE

A paediatric clinic where children were frequently brought by relatives or carers.

BEFORE

Consent was taken from whichever adult accompanied the child. No check of legal relationship. A grandmother consented to a minor procedure; the parents, who had not been told, complained. Adolescents were spoken about, not to. No age-appropriate explanation materials existed.

ACTION

A parental responsibility check was added to registration: who has legal responsibility, who is present, and — if the accompanying adult is not the legal decision-maker — documented phone consent from the responsible parent before treatment. Age-banded communication guidance was written for clinicians (under 5, 5–11, 12–15, 16+). Picture-based explanation cards were introduced for common procedures. Adolescents are offered part of the consultation alone.

AFTER

The Monitor reviewed 20 records with documented decision-maker verification; three showed phone consent from an absent parent. Observed a consultation with age-appropriate explanation to a seven-year-old. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add to registration: 'Who has legal responsibility for this child, and is that person here?'
2. Write a rule for when the accompanying adult is not the decision-maker.
3. Create simple explanation materials for children by age band.
4. Offer adolescents time alone.

The most common mistake: Taking consent from whoever brought the child — the person who drives is not necessarily the person who decides.

SELF-ASSESSMENT QUESTIONS

1. Is the legal decision-making authority of the accompanying adult specifically verified, not assumed? — *Genuine verification, not an assumption based on who happens to be present.*

Evidence: Decision-maker verification record

2. Is there a specific process for situations where the accompanying adult may not hold full decision-making authority? — *A known, specific process, not uncertainty about how to proceed.*

Evidence: Non-parent accompaniment protocol

3. Does the child receive age-appropriate communication about their own care, distinct from parental consent? — A genuine, separate step for the child, not consent obtained from the parent alone with the child excluded from the conversation entirely.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens for new patients but isn't reconfirmed for returning patients whose family circumstances may have changed.** — Custody and guardianship arrangements can genuinely change between visits.
- **A protocol exists for non-parent adults but staff aren't consistently confident applying it.** — A written protocol needs genuine staff familiarity to function as real protection.
- **Age-appropriate communication happens for older children but not younger ones capable of some understanding.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine decision-maker verification versus assumption.
Week 2	Establish or reinforce a specific protocol for non-parent accompanying adults.
Week 3	Build age-appropriate child communication into the standard visit structure.
Ongoing	Reconfirm decision-making authority periodically for returning patients.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Decision-maker verification review	Reviews records for evidence that decision-making authority is specifically verified, not assumed.
DOCUMENT	Non-parent protocol review	Reviews the specific process for situations involving a non-parent accompanying adult.

Method	What	Detail
OBSERVE	Child communication observation	Observes whether age-appropriate communication to the child happens as a distinct step.

SUPERVISOR TIPS

- **Ask staff how they'd handle a grandparent or other relative bringing in a child without the parent present.** — A specific, confident answer reveals genuine protocol readiness, not improvisation.
- **Observe whether the child is spoken to directly, not only about, during a visit.** — This reveals whether age-appropriate communication is genuine practice, not just a stated principle.

EVIDENCE BASE

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

ASF training courses on GMJ Academy →

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

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

NON-NEGOTIABLE

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

In plain terms: At every visit, the child's vaccination record is checked against the current national schedule, and any missing vaccine is identified and offered — not assumed up to date.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Every paediatric visit is a vaccination opportunity. Children fall behind — a missed appointment, a move, a parent's misunderstanding — and the gap is invisible unless someone looks. The check takes two minutes: the child's record against the schedule for their age. A missing vaccine is offered there and then, or scheduled. This is how measles outbreaks are prevented. A clinic that only vaccinates at 'vaccination visits' misses every child who came for something else — and those are often the ones who are behind.

WHAT GOOD LOOKS LIKE

- Vaccination status is actively checked at every visit, regardless of visit reason.
- Family-reported status is cross-checked against documented records where available.
- A specific, active process addresses any identified gap.

COMMON FAILURE MODES

- Vaccination status is checked only when specifically raised by the family.
- Family-reported status is accepted without any cross-check.
- An identified gap is noted but not actively addressed.

WORKED EXAMPLE

IN PRACTICE

A paediatric clinic seeing children for acute illness and well-child visits.

BEFORE

Vaccinations were reviewed only at scheduled well-child visits. Children seen for illness had no vaccination check. The Coordinator audited 50 records of children seen for acute illness: 18 were behind on at least one vaccine; none had been identified or offered catch-up.

ACTION

A vaccination status check was added to every visit, any reason: the nurse compares the record (or the national registry) against the schedule for

the child's age and documents the status; any gap is flagged to the clinician; catch-up vaccines are offered at the visit if the child is well enough, or scheduled within two weeks. A monthly audit tracks the proportion of visits with a check and the catch-up rate.

AFTER

The Monitor reviewed 40 records of acute visits: all had a documented vaccination check; nine gaps identified, seven vaccinated at the visit, two scheduled. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Audit 30 acute-visit records: was vaccination status checked?
2. Add a vaccination check to every visit template.
3. Offer catch-up at the visit, not later.
4. Track the catch-up rate monthly.

The most common mistake: Only checking vaccinations at well-child visits — the child who is behind is the one who misses those.

SELF-ASSESSMENT QUESTIONS

1. Is vaccination status actively checked against the current recommended schedule at every visit, not only when specifically raised? — *An active, routine check, not dependent on the visit's specific reason or family-initiated request.*

Evidence: Vaccination verification record

2. Is family-reported vaccination status cross-checked against a documented record where one exists, not accepted without verification? — *Genuine cross-checking against documentation, not accepted report alone.*

Evidence: Documentation cross-check process

3. When a gap is identified, is there a specific, defined process for addressing it, not just noting it? — *A real, active response, not passive documentation of a known gap.*

Evidence: Gap resolution protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens at well-child visits but not consistently at sick visits, even when overdue.** — A sick visit is still a genuine opportunity to catch and address an overdue vaccination gap.
- **Cross-checking happens when records are readily available but isn't actively pursued when they aren't.** — Actively seeking documentation, rather than only checking what's already at hand, closes more real gaps.
- **Gaps are identified and discussed but follow-through on actually closing them isn't tracked.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current vaccination verification practice across different visit types.
Week 2	Establish active verification at every visit, not only well-child visits.
Week 3	Build a specific gap resolution process with tracking to completion.
Ongoing	Audit gap identification and resolution tracking periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Verification practice review	Reviews records for active vaccination status verification at routine visits, not only when specifically raised.
DOCUMENT	Cross-check process review	Reviews whether family-reported status is cross-checked against documented records.
DOCUMENT	Gap resolution review	Reviews the specific process for addressing an identified vaccination gap.

SUPERVISOR TIPS

- **Ask whether vaccination status is checked during a sick visit specifically.** — This is where verification most commonly lapses relative to routine well-child visits.
- **Ask for a real example of an identified gap and how it was actually resolved.** — A real example reveals whether gap resolution

is genuine practice, not just identification.

EVIDENCE BASE

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

[ASF training courses on GMJ Academy →](#)

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

← **Ambulatory Clinic
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 22 —
Gastroenterology &
Endoscopy**

**Standard 24 — Medical
Tourism →**

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Standard 24 — Medical Tourism

10 criteria · 8 non-negotiable · 2 core · Version 3.0

CRITERIA IN THIS STANDARD

- 24.1 — Pricing Transparency for International Patients
- 24.2 — Remote Records Transfer to Home-Country Physician
- 24.3 — Language Access for Foreign Patients
- 24.4 — Travel, Accommodation, and Logistics Coordination
- 24.5 — Post-Return Complication Tracking
- 24.6 — Visa and Embassy Support Documentation
- 24.7 — International Patient Complaint and Redress Process
- 24.8 — Facilitators and Agents Are Verified, Not Assumed Legitimate
- 24.9 — Travel-Associated Infection Risk Protocol
- 24.10 — Post-Procedure Travel Timing and Venous Thromboembolism Risk

24.1 Pricing Transparency for International Patients

NON-NEGOTIABLE

International patients receive a complete, written, all-inclusive cost estimate before travel is booked — covering

the procedure and commonly needed extras — not a partial quote that grows once the patient has already committed to travelling.

In plain terms: International patients get a complete written cost estimate before they book travel — procedure, stay, and the extras that usually come up — with nothing hidden.

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

WHY THIS MATTERS

A patient who flies 3,000 km for surgery has no way to walk away when the bill is double the quote. They have spent on flights and hotels; they are far from home; they may be already admitted. Cost surprises for international patients are not only a complaint risk — they are a reputational catastrophe that spreads through the facilitator networks that bring patients. An all-inclusive estimate — procedure, anaesthesia, treatment area stay, standard medications, standard follow-up — with clearly stated exclusions and the conditions that could change it, is the basis of trust. It should be given in writing, in a language the patient reads, before they commit to travel.

WHAT GOOD LOOKS LIKE

- Every international patient receives a complete, written, all-inclusive estimate before booking.
- The estimate genuinely covers commonly needed extras, not just the base fee.
- A transparent, defined process exists for any genuine cost change.

COMMON FAILURE MODES

- Estimates are verbal, partial, or given only after the patient has already committed to travel.
- The quote covers only the base procedure, with predictable extras added later.
- Cost increases appear on the final bill without prior communication.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic receiving 200 international patients a year for orthopaedic and cosmetic surgery.

BEFORE	Estimates were given verbally by the international patient office and covered the surgeon's fee only. Patients arrived and were charged separately for anaesthesia, implants, extra nights, and medications. Complaints from international patients were three times the rate of domestic ones; two negative reviews on a facilitator's site cited 'hidden costs.'
ACTION	A standard estimate template was created per procedure: surgeon, anaesthesia, implants, expected stay, standard medications, one follow-up — total; plus a stated list of what is excluded and what circumstances could increase the cost. It is emailed in the patient's language before booking, with a signature line. Any charge outside the estimate requires the patient's written agreement.
AFTER	The Monitor reviewed 15 international patient files: all had signed estimates matching final invoices within stated exclusions. International patient complaints down 70%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten international patient files and compare the estimate given to the final bill.
2. Build an all-inclusive estimate template per common procedure, with stated exclusions.
3. Email it before booking, in the patient's language, with a signature.
4. Require written patient agreement for any charge outside the estimate.

The most common mistake: Quoting the surgeon's fee and treating everything else as 'extras' the patient should have expected.

SELF-ASSESSMENT QUESTIONS

1. Does every international patient receive a complete, written, all-inclusive estimate before booking travel? — *Written and complete, not a verbal figure that leaves room to grow later.*

Evidence: Written cost estimate documentation

2. Does the estimate cover commonly needed extras, not just the base procedure fee? — *Genuinely all-inclusive, not a narrow quote that predictably grows.*

Evidence: N/A — tested directly

3. Is there a specific process for handling a genuine, unforeseeable cost change once the patient has arrived? — *A defined, transparent process, not an unexplained addition to the bill.*

Evidence: Cost change communication protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Estimates are written and complete for the primary procedure but not for commonly bundled extras.** — A patient comparing quotes needs the genuinely full picture, not just the headline procedure cost.
- **The estimate is provided in writing but only after initial travel arrangements are already underway.** — The protective value of advance pricing depends on it arriving before the patient's negotiating position weakens.
- **A cost change process exists but isn't proactively explained to patients in advance.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current pricing communication practice against genuine advance, all-inclusive standard.
Week 2	Build a complete, written estimate template covering commonly needed extras.
Week 3	Establish a transparent process for communicating any genuine cost change.
Ongoing	Audit final costs against original estimates for a sample of patients.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Cost estimate review	Reviews written estimates provided to a sample of recent international patients for completeness.
ASK	Patient cost experience interview	Asks a recent international patient whether their final cost matched what they were quoted before travel.
DOCUMENT	Cost change protocol review	Reviews the process for communicating any genuine, unforeseeable cost change.

SUPERVISOR TIPS

- **Ask a recent international patient directly whether the final cost matched the original quote.** — This is the clearest, most direct test of genuine pricing transparency.
- **Ask to see a written estimate for a specific, real patient, not a generic template.** — A real example reveals whether the practice is genuinely followed, not just documented in policy.

EVIDENCE BASE

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

ASF training courses on GMJ Academy →

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

24.2 Remote Records Transfer to Home-Country Physician

NON-NEGOTIABLE

A complete, usable record of the care provided is genuinely transferred to the patient's home-country physician before

or immediately after the patient departs — not left to the patient to request, translate, and forward themselves.

In plain terms: When an international patient goes home, their own doctor receives a complete, usable record of what was done — not a one-line discharge note.

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

WHY THIS MATTERS

The patient's home-country physician will manage the recovery, the complications, and the follow-up — often for years. If all they receive is 'total hip replacement, uneventful,' they do not know the implant type, the antibiotic given, the anticoagulation plan, or what to watch for. A complication then becomes a mystery. A usable record means: operation note, implant details, medications on discharge with duration, follow-up plan, warning signs, and how to contact the operating surgeon — in a language the home physician reads, sent directly or given to the patient in a sealed form.

WHAT GOOD LOOKS LIKE

- A complete record handoff is genuinely completed and confirmed before or at departure.
- Records are provided in a form the home provider can actually use.
- A specific post-departure contact pathway is provided to every patient.

COMMON FAILURE MODES

- Records exist but handoff completion is never confirmed.
- Records are technically available but not in a usable language or format.
- No specific contact pathway exists for post-departure complications.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic performing joint replacements for patients from three neighbouring countries.

BEFORE

Patients left with a one-page discharge summary in the local language. Home physicians could not read it and did not know the implant type. A

	patient with a post-operative infection was treated with the wrong antibiotic at home because the home physician did not know what had been used. The clinic learned of this only when the patient's lawyer called.
ACTION	A structured international discharge pack was created: operation note, implant sticker, medication list with duration, follow-up schedule, five warning signs, and the surgeon's direct email — translated into English and the patient's language. It is emailed to the home physician (with consent) and given to the patient in print. A read-receipt is requested.
AFTER	The Monitor reviewed 12 international discharge packs and evidence of transmission to home physicians. Interviewed a home physician by email who confirmed the pack was usable. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Look at your current international discharge summary. Could a doctor in another country manage a complication from it?
2. Add: implant details, medications with duration, follow-up plan, warning signs, surgeon contact.
3. Translate into English and the patient's language.
4. Send directly to the home physician with the patient's consent.

The most common mistake: Sending the domestic discharge summary in the local language and assuming the patient will explain it to their doctor.

SELF-ASSESSMENT QUESTIONS

1. Is a specific, complete record handoff to the patient's home provider actually completed before or immediately after departure?
— *A genuine, completed handoff, not records that exist but were never actually transmitted or confirmed received.*

Evidence: Record handoff completion record

2. Are records provided in a form the home provider can actually use — appropriate language, standard format? — *Genuinely usable documentation, not technically provided but practically unusable.*

Evidence: N/A — tested directly

3. Is there a specific process for the patient to reach this facility if a complication arises after returning home? — *A specific, known contact pathway, not an assumption the patient would figure out how to reach someone.*

Evidence: Post-departure contact protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Handoff happens reliably when the home provider is known in advance but not when the patient hasn't identified one.** — Even without a named home provider, the patient still needs usable records and a contact pathway.
- **Records are provided but not translated into a language the likely home provider would use.** — Technically provided but practically unusable documentation doesn't achieve genuine continuity.
- **A contact pathway exists but isn't clearly communicated to the patient before they leave.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current handoff practice for genuine completion versus theoretical availability.
Week 2	Establish a process for translating records into a usable language and format.
Week 3	Establish and clearly communicate a specific post-departure contact pathway.
Ongoing	Confirm handoff completion for every international patient before departure.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Handoff completion review	Reviews records confirming actual completed handoff, not just record availability.

Method	What	Detail
OBSERVE	Record usability check	Checks whether handoff records are genuinely usable by a home provider, in appropriate language and format.
DOCUMENT	Post-departure contact review	Reviews the specific post-departure contact protocol provided to patients.

SUPERVISOR TIPS

- **Ask for a real, recent example of a completed handoff, not a description of the general process.** — A real example reveals whether handoff genuinely happens, not just theoretically exists as a policy.
- **Ask a patient directly how they'd reach this facility if a problem developed after they returned home.** — A confident, specific answer reveals whether the contact pathway was genuinely communicated.

EVIDENCE BASE

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

ASF training courses on GMJ Academy →

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

24.3 Language Access for Foreign Patients

NON-NEGOTIABLE

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

In plain terms: Foreign patients have a competent interpreter — not a family member or a staff member who 'speaks a bit' — for consent, treatment decisions, and discharge.

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

WHY THIS MATTERS

Consent obtained through a relative who softens the bad news is not consent. Discharge instructions given through a porter who speaks 'some English' are instructions half-understood. The moments that require an interpreter are exactly the moments when misunderstanding causes harm: what the surgery involves, what could go wrong, what to do at home. A competent interpreter — professional, or a trained bilingual staff member with a defined role — is a patient safety requirement, not a courtesy. Using children to interpret for parents is prohibited: it is unsafe and it burdens the child.

WHAT GOOD LOOKS LIKE

- A genuinely trained, competent interpreter is used consistently.
- Interpreter access is arranged in advance, matched to the patient's language.
- Patients can explain back key information in their own words.

COMMON FAILURE MODES

- Whichever staff member happens to speak some of the language is used ad hoc.
- Interpreter arrangements are improvised on the day of the visit.
- Patients cannot explain back consent or aftercare information.

WORKED EXAMPLE

IN PRACTICE

A 16-room clinic treating patients from six language groups.

BEFORE

Interpretation was ad hoc — a family member, a nurse who spoke the language, occasionally a phone app. The Coordinator observed a consent conversation for a hysterectomy interpreted by the patient's teenage son. A post-operative

	patient was readmitted after misunderstanding discharge instructions interpreted by a cleaner.
ACTION	The clinic contracted a telephone interpretation service covering 40 languages, available 24 hours. Four bilingual staff completed a two-day medical interpreter course and were listed with their languages. A rule was written: consent, treatment discussions, and discharge for non-native speakers require a listed interpreter or the phone service; family members may assist but not substitute; children never interpret. Interpreter use is documented.
AFTER	The Monitor reviewed 15 international patient records: interpreter documented at consent and discharge in all. Observed a phone-interpreted consultation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask how the last five non-native-speaking patients gave consent. Who interpreted?
2. Contract a phone interpretation service — cost is per minute and modest.
3. Train two to four bilingual staff as interpreters.
4. Write the rule: listed interpreter for consent and discharge; never a child.

The most common mistake: Treating a family member as an interpreter — they edit, soften, and mistranslate, and the patient's consent is compromised.

SELF-ASSESSMENT QUESTIONS

1. Is a genuinely competent, trained interpreter used for consent, treatment discussion, and aftercare instructions? — *Trained interpreter competency, not ad hoc bilingual staff pressed into service.*
Evidence: Interpreter engagement record
2. Is interpreter access arranged before the patient arrives, not improvised on the day? — *Planned in advance, matched to the*

patient's actual language.

Evidence: N/A — tested directly

3. Can the patient explain back key consent and aftercare information in their own words? — *Tests genuine understanding, not just that interpretation technically occurred.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A trained interpreter is used for the main consultation but not for aftercare instructions at discharge.** — Aftercare instructions carry real, ongoing risk if misunderstood after the patient has left.
- **Interpreter access exists but isn't confirmed until the patient has already arrived.** — Advance confirmation avoids a scramble that risks falling back on ad hoc arrangements.
- **Interpretation occurs but understanding is never actively checked afterward.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current interpreter arrangements for international patients.
Week 2	Establish advance booking of trained interpreters matched to expected patient languages.
Week 3	Extend interpreter use explicitly to aftercare instruction, not only initial consultation.
Ongoing	Spot-check patient understanding after interpreted consultations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Interpreter engagement review	Reviews records for genuine, trained interpreter engagement, not ad hoc bilingual staff use.
ASK	Advance arrangement interview	Asks staff how interpreter access is arranged before an international patient's arrival.
OBSERVE	Patient understanding check	Checks whether the patient can explain back key consent and aftercare information.

SUPERVISOR TIPS

- **Ask specifically about aftercare instruction interpretation, not just the main consultation.** — This is where interpreter use most commonly lapses.
- **Ask a patient to explain back their own aftercare instructions.** — This tests genuine understanding, not just that an interpreter was present.

EVIDENCE BASE

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

[ASF training courses on GMJ Academy →](#)

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

24.4 **Travel, Accommodation, and Logistics Coordination** CORE

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

In plain terms: The clinic helps international patients with the logistics around their treatment — arrival, accommodation, transport — rather than leaving a recovering patient in a foreign city to manage alone.

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

WHY THIS MATTERS

A patient leaving the clinic after surgery in a city where they know no one, do not speak the language, and have a flight in four days is a patient at risk. They may not find a pharmacy, may not know where to go if a wound bleeds, may take a taxi to the wrong clinic. Coordination need not mean running a travel agency; it means a named contact, a

list of verified nearby accommodation, arranged transport from airport and between hotel and clinic, and clear instructions for what to do if something goes wrong before the flight home. It is part of the clinical pathway, not a clinicity extra.

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

IN PRACTICE	
<i>A 8-room clinic where international patients arranged their own logistics.</i>	
BEFORE	Patients booked their own hotels — sometimes an hour away, sometimes with no lift for a post-operative knee patient. One arrived at 3am with no transport. One was leaving the clinic to a hostel with stairs and no one to help. The international office gave a phone number that was answered only in office hours.
ACTION	An international patient coordinator role was created: airport pick-up arranged for every patient; a list of five vetted hotels within 15 minutes, each with a lift and 24-hour reception; transport to and from the clinic; a 24-hour emergency number; a printed 'what to do if' card. Coordination was included in the estimate (8.1).
AFTER	The Monitor reviewed the coordinator's log for 20 patients: all with airport transfer, vetted accommodation, and the emergency number

issued. Two emergency calls handled within the previous quarter. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask the last five international patients how they found accommodation and got to the clinic.
2. Vet five hotels near the clinic for accessibility and 24-hour reception.
3. Arrange airport transfer for every international patient.
4. Issue a 24-hour number and a 'what if' card at discharge.

The most common mistake: Treating logistics as the patient's problem — a post-operative patient in a foreign city with no support is a clinical risk.

SELF-ASSESSMENT QUESTIONS

1. Does the facility provide or genuinely coordinate travel and accommodation support, not just a list of options? — *Real coordination, not information the patient must act on entirely alone.*
Evidence: Logistics coordination documentation
2. Is accommodation genuinely suitable for post-procedure recovery, not just conveniently located? — *Suitability for actual recovery needs, not proximity alone.*
Evidence: N/A — tested directly
3. Is there a specific point of contact for logistics problems during the patient's stay? — *A specific, known contact, not an assumption the patient will manage independently.*
Evidence: Logistics contact protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Coordination support is offered for the arrival but not for the return journey.** — Logistics risk doesn't end once the procedure itself is complete.
- **Accommodation recommendations exist but aren't verified for genuine recovery suitability.** — A recommendation that hasn't been checked may not actually suit a recovering patient's needs.
- **A contact exists but isn't clearly communicated or reachable outside office hours.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current logistics support against genuine coordination versus informational lists.
Week 2	Verify recommended accommodation options for genuine recovery suitability.
Week 3	Establish a specific, reachable logistics contact for the duration of the stay.
Ongoing	Gather patient feedback on logistics coordination quality.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Coordination support review	Reviews what genuine travel and accommodation coordination is provided, not just informational lists.
ASK	Accommodation suitability interview	Asks whether recommended or arranged accommodation genuinely suits post-procedure recovery needs.
DOCUMENT	Logistics contact review	Reviews the specific point of contact provided for logistics issues during the stay.

SUPERVISOR TIPS

- **Ask a recent international patient how logistics support actually worked in practice.** — Real experience reveals more than a description of intended coordination.
- **Ask what happens if a logistics problem arises outside office hours.** — This reveals whether support is genuinely continuous, not just during standard hours.

EVIDENCE BASE

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

[ASF training courses on GMJ Academy](#) →

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

24.5 Post-Return Complication Tracking

NON-NEGOTIABLE

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

In plain terms: The clinic follows up with international patients after they go home — and actively tracks complications, including ones their home doctor finds.

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

WHY THIS MATTERS

Once the patient flies home, most clinics never hear from them again — unless they sue. That means the clinic does not know its own complication rate for international patients, cannot learn from it, and cannot improve. A wound infection diagnosed in the home country, an implant failure at six months, a DVT on the flight home: each is data the clinic needs. Active tracking means scheduled contact at defined intervals — one week, one month, three months — by email or phone, with a simple question set, and a way for the home physician to report. It is the only way to know whether the international programme is safe.

WHAT GOOD LOOKS LIKE

- An active, structured process tracks international patient outcomes after return.
- A specific, known pathway exists for home-country physicians to report complications.
- Tracked complications are genuinely reviewed and inform practice.

COMMON FAILURE MODES

- Tracking relies on a single generic follow-up call with no structured process.
- No pathway exists for a home-country physician to report a complication.
- Complications, if tracked, are recorded but never reviewed for learning.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic that had no contact with international patients after discharge.

BEFORE	The clinic reported 'no complications' in international patients because it had no way to know. A facilitator mentioned three patients from one country who had developed infections after returning home; none had been reported to the clinic. Outcome data for international surgery was entirely absent.
ACTION	A post-return follow-up protocol was set: email at day 7, day 30, and day 90 with a five-question form in the patient's language; a phone call if no response; a direct email address for home physicians to report complications. Responses were logged and reviewed monthly. Complications were entered into the same surveillance system as domestic patients.
AFTER	The Monitor reviewed six months of follow-up data: 78% response rate; 4 complications identified and reviewed, one leading to a change in discharge anticoagulation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask: what is your complication rate for international patients? If you don't know, that's the finding.
2. Set three follow-up points — 7, 30, 90 days — with a short question set.
3. Give home physicians a direct email to report problems.
4. Log every response and review monthly.

The most common mistake: Reporting zero complications in international patients because you have never asked.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, active process for tracking international patient outcomes after they return home, not just a generic courtesy call? — *An active, structured process, not a single, easily-missed follow-up attempt.*

Evidence: Post-return tracking protocol

2. Is there a specific pathway for a home-country physician to report a complication back to this facility? — *A real, known pathway, not an assumption the physician would somehow know how to reach the facility.*

Evidence: Physician reporting pathway

3. Are tracked complications reviewed and used to inform practice, not just recorded? — *Genuine learning from real outcomes, not passive record-keeping.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Follow-up happens once but isn't repeated if the patient doesn't respond the first time.** — A single missed attempt shouldn't end the tracking process for a real complication risk.
- **A reporting pathway exists but isn't communicated to the patient or their home provider.** — An unknown pathway provides no real function.
- **Complications are recorded but never reviewed collectively for patterns.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current post-return follow-up practice for structure versus a single generic attempt.
Week 2	Establish a specific pathway for home-country physicians to report complications.
Week 3	Build a process for reviewing tracked outcomes and feeding findings into practice.
Ongoing	Track complication rates and review for patterns periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Tracking protocol review	Reviews the specific, active process for tracking international patient outcomes after return.
DOCUMENT	Physician reporting pathway review	Reviews the specific pathway for a home-country physician to report a complication.
ASK	Outcome review interview	Asks staff for a real example of a tracked complication that informed a practice change.

SUPERVISOR TIPS

- **Ask for a real example of a complication learned about after a patient returned home.** — A real example, or its honest absence, reveals whether tracking genuinely functions.
- **Ask how a home-country physician would actually reach this facility to report a concern.** — A specific, confident answer reveals a genuine pathway, not an assumed one.

EVIDENCE BASE

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

[ASF training courses on GMJ Academy →](#)

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

24.6 Visa and Embassy Support Documentation

CORE

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

In plain terms: The clinic provides the specific paperwork international patients need for medical visas and embassies — correctly, in the right format, and on time.

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

WHY THIS MATTERS

A medical visa application needs a letter from the treating clinic stating the diagnosis, the treatment, the dates, the estimated cost, and often a guarantee of accommodation. Each embassy has its own format. A letter that is late, wrongly formatted, or missing a required element means the patient's visa is refused and the surgery is cancelled — with the clinic having lost the case and the patient having lost weeks. This is administrative, not clinical, but it is on the critical path. A clinic serious about international patients has a template for each common embassy and a turnaround commitment.

WHAT GOOD LOOKS LIKE

- Documentation is specific, correct, and matched to actual visa requirements.
- Documentation is provided with realistic lead time for processing.
- A specific, responsive correction process exists for errors.

COMMON FAILURE MODES

- Documentation is generic, leaving the patient to determine actual requirements.
- Documentation arrives too close to travel dates for realistic processing.
- Errors, when identified, take a long time to correct.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic receiving patients from four countries with different visa requirements.

BEFORE

Visa letters were written ad hoc by the international office when asked. Two patients had visas refused because the letter lacked the embassy's required elements. Turnaround was up to two weeks. Nobody had checked what each embassy actually required.

ACTION	The international coordinator contacted the four relevant embassies and obtained their exact requirements. A template per embassy was created. A commitment was set: visa letter within three working days of request. A checklist was used before sending. The templates were reviewed annually.
AFTER	The Monitor reviewed the four templates, the embassy requirement documents, and a log showing 30 letters issued in three months, all within three days, no refusals attributed to letter deficiencies. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the countries your international patients come from.
2. Contact each embassy and get their exact medical visa letter requirements in writing.
3. Build a template per embassy.
4. Commit to a turnaround time and track it.

The most common mistake: Writing a generic 'to whom it may concern' letter and assuming every embassy will accept it.

SELF-ASSESSMENT QUESTIONS

1. Does the facility provide the specific documentation needed for medical visa applications, correctly and promptly? — *Specific, correct documentation matched to actual requirements, not generic paperwork.*

Evidence: Visa documentation record

2. Is documentation provided with enough lead time for realistic visa processing? — *Genuine lead time, not documentation issued so late that delay becomes likely.*

Evidence: N/A — tested directly

3. Is there a specific process for correcting a documentation error quickly if one is identified? — *A specific, responsive process, not a slow, informal correction path.*

Evidence: Documentation correction protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Documentation is generally correct but not verified against the specific requirements of every relevant country.** — Requirements genuinely vary by country, and a generic approach risks missing country-specific needs.
- **Lead time is adequate for common cases but not for countries with longer processing times.** — Processing time varies significantly by country, and lead time should reflect the patient's actual situation.
- **A correction process exists but isn't clearly known to staff handling these requests.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current visa documentation practice for accuracy and lead time.
Week 2	Establish country-specific documentation checklists for common patient origins.
Week 3	Establish a specific, responsive correction process for documentation errors.
Ongoing	Track visa-related delays and adjust lead time practice accordingly.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Documentation accuracy review	Reviews visa and embassy documentation provided to a sample of international patients for correctness.
ASK	Lead time interview	Asks staff how far in advance documentation is typically provided relative to expected processing time.
DOCUMENT	Correction process review	Reviews the process for quickly correcting a documentation error if identified.

SUPERVISOR TIPS

- **Ask for a real example of documentation provided for a specific country's requirements.** — A real, specific example reveals

genuine accuracy, not a generic template.

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

EVIDENCE BASE

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

ASF training courses on GMJ Academy →

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

24.7 International Patient Complaint and Redress Process

NON-NEGOTIABLE

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

In plain terms: International patients can complain and seek redress from their home country — and there is evidence that such complaints are genuinely addressed.

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

WHY THIS MATTERS

A patient who flew home with a complication and a grievance is not going to fly back to file a complaint at the front desk. If the clinic's complaint process only works in person, international patients effectively have no complaint process. And a patient with no route to complaint becomes a patient who complains publicly — to the facilitator, on review sites, to their embassy. A working process means

an email or web form, a response commitment, a named person, and — for disputes — a defined redress mechanism: a refund policy, a mediation route, or a stated arbitration process. The evidence required is that complaints have been received from abroad and resolved.

WHAT GOOD LOOKS LIKE

- The complaint channel is genuinely reachable and usable from the patient's home country.
- The channel is accessible in relevant languages, not only the local one.
- Real, documented evidence shows complaints are genuinely addressed.

COMMON FAILURE MODES

- The complaint process functionally requires physical presence or local language fluency.
- No accommodation exists for patients who don't speak the local language.
- No documented evidence exists that complaints from returned patients are addressed.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic whose complaints process was a form at reception.

BEFORE

No international patient had ever formally complained — because there was no way to. The facilitator reported that two patients had complained to them about the clinic; the clinic had never heard about it. A review site showed three negative reviews from international patients, none of which the clinic had responded to.

ACTION

An international complaints email and web form were created, in three languages. The international coordinator was named as the responsible person with a 5-day acknowledgement and 30-day resolution commitment. A redress policy was written: what triggers a refund, how disputes are escalated, and an external mediation option through the facilitator association. Review-site comments were monitored and responded to.

AFTER

The Monitor reviewed the log: 7 complaints from abroad in six months, all acknowledged and resolved, two with partial refunds. Reviewed the redress policy. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Try to complain about your clinic from abroad. Is it possible?
2. Create an email and web form in your patients' languages.
3. Name a person and set response times.
4. Write a redress policy: when a refund applies, how disputes escalate.

The most common mistake: Reporting zero international complaints because there is no way to make one.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific complaint channel genuinely reachable from the patient's home country, not requiring physical presence? — *Genuine remote accessibility, not a channel that functionally only works locally.*

Evidence: Complaint channel documentation

2. Is the complaint channel accessible in relevant languages, not only the local language? — *Genuine language accessibility, not a barrier that excludes exactly the patients most likely to need it.*

Evidence: N/A — tested directly

3. Is there real, documented evidence that complaints from returned patients are actually addressed? — *Genuine follow-through, not a channel that exists but produces no real response.*

Evidence: Complaint resolution record

COMMON REASONS FOR A PARTIAL ANSWER

- **A remote complaint channel exists but response times are significantly slower than for local complaints.** — A technically accessible channel that responds too slowly doesn't provide genuine redress.
- **The channel is accessible by email but not genuinely responsive to patients writing in other languages.** — Technical accessibility without genuine language responsiveness doesn't achieve real access.

- **Complaints are received but resolution isn't consistently documented or communicated back to the patient.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current complaint channel for genuine remote and language accessibility.
Week 2	Establish or strengthen remote-accessible complaint intake in relevant languages.
Week 3	Establish documented resolution tracking with communication back to the patient.
Ongoing	Track response times and resolution rates for international patient complaints specifically.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **Ask for a real example of a complaint received from a patient after they had already returned home.** — A real example reveals whether the channel genuinely functions for exactly the patients who need it most.
- **Test the complaint channel's accessibility in a language other than the local one.** — This directly reveals genuine language accessibility, not an assumption of it.

EVIDENCE BASE

[107] Cross-border patient redress mechanisms are identified in international medical travel governance literature as a distinct requirement

from domestic complaint processes, given the specific access barriers international patients face after returning home.

ASF training courses on GMJ Academy →

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

24.8 **Facilitators and Agents Are Verified, Not Assumed Legitimate**

NON-NEGOTIABLE

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

In plain terms: Every medical tourism facilitator or agent who refers patients to the clinic is checked — real business registration, real track record — and the check is documented, not assumed.

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

WHY THIS MATTERS

This is the ambulatory equivalent of hospital 8.8. A facilitator who promises patients results the clinic cannot deliver, hides commissions, or vanishes when a complication occurs, damages the clinic as much as the patient. Verification means: legal registration confirmed; references from other facilities; a signed agreement covering what they may promise, commission disclosure, and termination; and a file that shows the check was done. A clinic that accepts patients from unverified agents has outsourced its reputation to strangers.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Each facilitator is specifically verified for legitimate registration and track record.
- Verification is documented and periodically reconfirmed.
- A specific process reviews what facilitators actually represent to patients.

- Facilitators are accepted based on referral volume without specific verification.
- Verification, if it happened, was never reconfirmed after initial acceptance.
- No process exists to review what facilitators actually tell patients.

WORKED EXAMPLE

IN PRACTICE

An ambulatory surgical clinic receiving international patients through five agents.

BEFORE

Agents were engaged by phone. No registration was checked. One agent had told patients the clinic's surgeon was 'the best in Europe' and quoted prices 40% above the clinic's own. The clinic had no written agreement with any agent.

ACTION

An agent verification standard was written: registration confirmed with the relevant authority; two references from other facilities; a signed agreement on permitted claims, commission disclosure, and termination; an annual review. All five agents were reviewed; one was terminated. Patients are given the clinic's own price list directly.

AFTER

The Monitor reviewed four agent files with registration evidence, references, and signed agreements. Interviewed an international patient who confirmed receiving the clinic's direct price list. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every agent who sends you patients.
2. For each, confirm legal registration and get two references.
3. Sign a one-page agreement on claims and commissions.

4. Give patients your price list directly.

The most common mistake: Assuming an agent who has sent patients for years is legitimate — longevity is not verification.

SELF-ASSESSMENT QUESTIONS

1. Is each facilitator or agent specifically verified for legitimate business registration and a checkable track record? — *Genuine, specific verification, not accepted based on referral volume or marketing professionalism alone.*

Evidence: Facilitator verification record

2. Is verification documented and periodically reconfirmed, not done once and assumed to remain valid indefinitely? — *An active, periodically reconfirmed process, not a one-time check.*

Evidence: Periodic reconfirmation record

3. Is there a specific process for reviewing what a facilitator actually tells patients about this facility? — *Active oversight of facilitator representations, not an assumption they accurately represent the facility.*

Evidence: Facilitator representation review process

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens for new facilitator relationships but isn't reconfirmed for long-standing ones.** — A facilitator's legitimacy and practices can change over time even after an initial, valid verification.
- **Verification covers business registration but not the accuracy of their patient-facing representations.** — A legitimately registered facilitator can still misrepresent risks or outcomes to patients.
- **Patients occasionally arrive with expectations that don't match what the facility actually offers.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current facilitator relationships for specific verification versus assumed legitimacy.
Week 2	Establish or strengthen documented verification for every facilitator relationship.
Week 3	Build a periodic reconfirmation schedule and a process for reviewing facilitator representations.

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

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Facilitator verification review	Reviews verification records for business registration and track record for each facilitator.
DOCUMENT	Reconfirmation schedule review	Reviews whether verification is periodically reconfirmed, not a one-time check.
ASK	Representation review interview	Asks staff how they review what facilitators actually tell patients about the facility.

SUPERVISOR TIPS

- **Ask for the actual verification record for a specific, named facilitator.** — A specific, documented record is the real evidence of genuine verification, not assumed legitimacy.
- **Ask a recent international patient what they were told by their facilitator before arrival.** — This reveals whether facilitator representations actually match facility reality.

EVIDENCE BASE

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

[ASF training courses on GMJ Academy →](#)

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

24.9 Travel-Associated Infection Risk Protocol

NON-NEGOTIABLE

International patients are assessed for travel-associated infection risk specific to their journey and country of origin,

with appropriate screening and precautions applied — not treated identically to a local patient with no recent travel history.

In plain terms: International patients are assessed for infection risks specific to where they came from and how they travelled — and screened or isolated accordingly.

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

WHY THIS MATTERS

A patient arriving from a region with endemic MDR-TB, or who spent 20 hours in transit, or who was recently in a clinic in a country with high carbapenem-resistant organism rates, carries risks the domestic registration process does not consider. Failing to screen means the patient may be placed in a shared bay, may infect other patients, and may have their own surgery complicated by an unrecognised infection. A short travel-risk assessment at registration — where from, recent clinicisation abroad, symptoms, vaccination status — with a defined response (screening swabs, isolation pending results) is standard infection control practice for any facility receiving international patients.

WHAT GOOD LOOKS LIKE

- International patients undergo a specific, distinct travel-associated infection risk assessment.
- The assessment reflects the patient's specific country of origin and travel history.
- Appropriate precautions are genuinely applied based on the assessment.

COMMON FAILURE MODES

- International patients are assessed identically to local patients with no travel-specific step.
- The assessment is generic, not reflecting the patient's actual journey.
- Precautions are documented but not genuinely applied in practice.

WORKED EXAMPLE

IN PRACTICE

A 16-room clinic receiving patients from three regions with high antimicrobial resistance rates.

BEFORE	International patients were admitted like domestic patients. No travel history was taken. A patient from a region with high CRE prevalence was placed in a four-bed bay; CRE was later isolated from a wound and from two other patients in the bay. Infection control had no travel-risk protocol.
ACTION	A travel-risk screen was added to international registration: country of origin, clinicisation abroad in the last 12 months, TB symptoms, recent antibiotic use. Patients from defined high-risk regions or with recent foreign clinicisation are swabbed for MDR organisms and isolated in a single room pending results. A regional risk list is maintained by infection control and updated annually.
AFTER	The Monitor reviewed 20 international registrations: all screened; 6 isolated pending swabs, 1 positive and managed appropriately. Reviewed the risk list. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add four questions to international registration: origin, foreign clinicisation, TB symptoms, recent antibiotics.
2. Define which answers trigger screening swabs and isolation.
3. Ensure single-room capacity for pending-result isolation.
4. Ask infection control to maintain a regional risk list.

The most common mistake: Admitting international patients through the domestic pathway with no travel history — the risk is not visible until it has spread.

SELF-ASSESSMENT QUESTIONS

1. Are international patients specifically assessed for travel-associated infection risk, not treated identically to local patients? — *A specific, distinct assessment step, not folded into or skipped within general intake.*

Evidence: Travel-associated infection risk assessment

2. Does the assessment account for the patient's specific country of origin and recent travel history? — *Specific to this patient's actual journey, not a generic travel question.*

Evidence: N/A — tested directly

3. Are appropriate precautions applied based on the assessment, not just documented without changing practice? — *Genuine, applied precautions, not an assessment that doesn't change anything.*

Evidence: Precaution application record

COMMON REASONS FOR A PARTIAL ANSWER

- **The assessment happens for surgical procedures but not consistently for other invasive procedures.** — Travel-associated infection risk applies to any procedure carrying genuine infection exposure, not surgery alone.
- **Country of origin is recorded but not specifically used to inform the risk assessment.** — Recorded information that doesn't inform the actual assessment provides no real protective value.
- **Precautions are identified but application is inconsistent across different staff.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current intake practice for a specific travel-associated infection risk step.
Week 2	Build a structured assessment reflecting country of origin and travel history.
Week 3	Establish consistent application of indicated precautions across all staff.
Ongoing	Audit assessment completion and precaution application for international patients.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Risk assessment review	Reviews records for a specific, distinct travel-associated infection risk assessment.
DOCUMENT	Assessment specificity review	Reviews whether assessment content reflects the patient's specific country of origin and travel history.

Method	What	Detail
OBSERVE	Precaution application check	Checks whether precautions indicated by the assessment are genuinely applied in practice.

SUPERVISOR TIPS

- **Ask to see the specific travel-associated risk assessment for a recent international patient.** — A specific, real example reveals whether this is genuine practice, not just a policy statement.
- **Ask staff how the assessment differs for patients from different countries of origin.** — A specific, informed answer reveals genuine understanding, not a generic infection-control response.

EVIDENCE BASE

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

ASF training courses on GMJ Academy →

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

24.10 Post-Procedure Travel Timing and Venous Thromboembolism Risk

NON-NEGOTIABLE

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

In plain terms: Every international patient gets a specific conversation about when it is safe to fly home — and about the raised blood clot risk from surgery plus long travel.

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

WHY THIS MATTERS

A patient who has just had a hip replacement, a caesarean, or major abdominal surgery, then sits immobile in an aircraft for eight hours, has a substantially elevated risk of a blood clot in the leg that can travel to the lung and kill. This is well documented and almost entirely preventable: wait a defined period before flying, take the prescribed anticoagulant, wear compression stockings, walk during the flight. Yet many clinics discharge international patients without mentioning it, because the flight is 'the patient's business.' It is not. A documented conversation — with the minimum wait, the prophylaxis plan, and the in-flight precautions — is the clinic's responsibility.

WHAT GOOD LOOKS LIKE

- Every international patient receives a specific, documented travel timing discussion.
- The discussion specifically names blood clot risk, not general recovery advice alone.
- Patients can explain back the specific recommended timing for their own procedure.

COMMON FAILURE MODES

- Travel timing is left to general recovery instructions without specific discussion.
- Blood clot risk isn't specifically named or explained.
- Patients cannot describe any specific recommended timing.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic performing orthopaedic surgery on patients who fly home within days.

BEFORE

Flight timing was the patient's decision. Patients booked return flights before surgery, often for two days after discharge. No VTE conversation was documented. Two international patients had developed pulmonary emboli after flying home in the previous year; the clinic learned of one through a lawyer.

ACTION

A post-procedure travel protocol was written per procedure type: minimum days before flying, anticoagulation to continue through travel, compression stockings, in-flight mobility instructions. The conversation is documented in a specific discharge section and the patient signs. Patients are advised at the estimate stage (8.1) not to book return flights until the surgeon confirms.

AFTER

The Monitor reviewed 15 international discharges: all had the travel timing section completed and signed, with anticoagulation and stockings prescribed. No VTE events in the following six months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask the last five international patients how many days after surgery they flew home.
2. Write a minimum wait per procedure with your surgeons.
3. Add a travel timing section to international discharge with a signature.
4. Tell patients at booking not to fix their return flight until cleared.

The most common mistake: Treating the flight home as the patient's decision when the clot risk is a direct consequence of the surgery you performed.

SELF-ASSESSMENT QUESTIONS

1. Does every international patient receive a specific, documented discussion of safe travel timing for their specific procedure? — *A specific, procedure-appropriate discussion, not a generic travel disclaimer.*

Evidence: Travel timing discussion documentation

2. Is the discussion specific to blood clot risk from combining this procedure with air travel, not general recovery advice? — *The specific risk named directly, not folded into general aftercare instructions.*

Evidence: N/A — tested directly

3. Can the patient explain back the recommended minimum time before flying, specific to their own procedure? — *Tests genuine understanding specific to this patient, not general awareness that travel timing matters.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The discussion happens for major procedures but is abbreviated for shorter or perceived lower-risk ones.** — Even shorter procedures combined with long-haul travel carry genuine, documented risk.
- **Timing is mentioned but the specific reasoning behind it isn't explained.** — Understanding why matters for a patient weighing their own travel decision against the recommendation.
- **The discussion happens but isn't documented, relying on staff memory that it occurred.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for specific, documented travel timing discussion.
Week 2	Build a specific, procedure-appropriate travel timing script into pre-departure counselling.
Week 3	Establish documentation confirming the discussion occurred for every international patient.
Ongoing	Spot-check patient understanding of their specific recommended timing.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Travel timing documentation review	Reviews records for a specific, procedure-appropriate travel timing discussion.
OBSERVE	Discussion specificity observation	Observes whether the discussion specifically names blood clot risk, not general recovery advice alone.

Method	What	Detail
ASK	Patient understanding check	Asks a patient to explain back the recommended travel timing specific to their procedure.

SUPERVISOR TIPS

- **Ask an international patient directly what they were told about travel timing.** — This tests actual understanding, not just that a conversation is assumed to have occurred.
- **Check documentation for a shorter, perceived lower-risk procedure specifically.** — This is where the discussion most commonly gets abbreviated or skipped.

EVIDENCE BASE

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

ASF training courses on GMJ Academy →

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

← **Ambulatory Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 23 — Pediatric Ambulatory Care**

Standard 25 — Refugee & Migrant Health →

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