



International Surgery (I-Surg)

ACCREDITATION STANDARDS MANUAL

Version 5.1, Effective February 2, 2026

SURVEY INSTRUCTIONS

Please complete the Standards Manual for the facility by assessing compliance with the standards contained in this book.

STANDARDS STRUCTURE

Standards found in this book are organized by grouping relevant standards together. These groupings are comprised of “Sections,” “Sub-sections,” and then individual standard numbers. Each main “Section” is identified by a numerical value, “Sub-sections” have been assigned an alphabetical value, and the individual standards under the subsection have also been numbered. Based on this format, each standard has been assigned a unique identifier to include all three elements to indicate its location.

For example: The standard which states, “Each operating room is properly cleaned, maintained and free of litter and clutter” is the fourth standard under Section 2, Sub-section C. Therefore, the unique identifier for this standard is: 2-C-4.

Please note that not all standards are necessarily in continuous sequential order. Some numbers have been reserved for future use and do not appear in the manual. The groupings within the Sections and Sub-sections of this book are intended to separate standards into logical sets of standards. Based on 40 years’ experience, such groups are likely, but not guaranteed, to be found and assessed during the same portion of the survey process.

The standards are organized into a logical hierarchy for ease of use:

- **Sections** are numbered (e.g., 1, 2, 3).
- **Sub-sections** are assigned a letter (e.g., A, B, C).
- **Individual Standards** are numbered under each sub-section (e.g., 1, 2, 3).

This structure creates a unique identifier for each standard: **[Section]-[Sub-section]-[Standard #]**.

Example: The standard, “*Each operating room is properly cleaned, maintained and free of litter and clutter,*” is the fourth standard in Section 2, Sub-section C. Its identifier is **2-C-4**.

Please Note:

- Standard numbers are not always sequential. Some numbers are reserved for future use and do not appear in this edition.
- The groupings are designed to cluster related standards, which may facilitate a more efficient survey process.

STANDARDS BOOK LAYOUT

The standards manual layout consists of five (5) columns. The function of each column is as follows:

Standard ID:

This column contains the alphanumeric identifier for each standard.

Class:

This column indicates the anesthesia classification, based on QUAD A definitions, that is applicable to the standard. Only facilities that provide anesthesia meeting the definition of one or more of the classifications listed in this column are required to comply with it.

Note: Facilities must comply with all applicable state or national requirements governing the facility, including country and state laws and regulations relating to anesthesia. When standards conflict, **the most stringent requirement applies**, unless mandated by laws or regulations applicable to the facility.

Example: A facility accredited under QUAD A Class A Standards may be permitted to administer local, topical anesthesia, minimal sedation, or nitrous oxide using a standalone system for administration. However, if the facility's state or country has a Class A-equivalent designation that *specifically limits anesthesia to local or topical anesthesia only*, then the facility must follow the state or national requirement. In this case, the facility **may not** administer oral medications to achieve minimal sedation, even if accreditation standards would otherwise allow it.

Standard / Regulatory Reference:

This column contains the text for each standard. It also indicates the corresponding regulatory reference (e.g., CMS, DHA, Florida, etc.), if applicable.

Interpretive Guidance:

This column indicates the interpretive guidance (IG) that correlates with the standard.

INTERPRETIVE GUIDANCE (IG)

Interpretive Guidance (IG) is provided to support the understanding and application of QUAD A standards. IGs are **explanatory tools**, not requirements, and are **not used as scorable elements** during the accreditation process.

Purpose of Interpretive Guidance

Interpretive Guidance is intended to:

- **Clarify the intent** of a standard by explaining the underlying objectives related to patient safety and quality.
- **Offer examples** of acceptable methods, processes, or documentation that a facility *may* use to demonstrate compliance. These examples are illustrative and not mandatory.
- **Promote consistency** among surveyors by identifying common areas of review and evidence-gathering related to the standard.
- **Encourage continuous improvement** as facilities assess their policies and procedures in relation to the goals of the standard.

Use of IGs in the Accreditation Process

Interpretive Guidance supplements the standards but **does not function as an additional layer of requirements**. Accreditation decisions are based solely on a facility's compliance with the published QUAD A standards.

- IG examples are **not scoreable** and cannot be used as the basis for a citation.
- A facility may demonstrate compliance through methods other than those listed in an IG, as long as the approach meets the requirements of the standard.
- Conversely, mirroring an IG example does not guarantee compliance if the underlying standard is not effectively met or implemented.

Survey Application

During the on-site survey:

1. **The Standard Serves as the Benchmark**
Surveyors evaluate compliance directly against the language of the standard.
2. **The IG Informs the Review Process**
Surveyors use IGs to guide their inquiry, including selecting relevant questions and identifying appropriate sources of evidence.
Example: If a standard requires a "qualified circulator," the IG may suggest reviewing credentials or competency assessments. Evidence of qualifications may be demonstrated through personnel files, competency documentation, or other facility-established methods.
3. **Compliance Is Evidence-Based**
The surveyor determines compliance by assessing whether the evidence provided—regardless of format—meets the requirement described in the standard.

SCORING COMPLIANCE

The QUAD A accreditation program mandates 100% compliance with every standard to achieve and maintain accreditation, without exception. If a surveyor observes a single instance of non-compliance, the standard is scored as "Deficient." The facility must submit both a Plan of Correction, as well as documented Evidence of Corrections.

Applicable standard(s) will be given a score of deficient.

QUAD A withholds accreditation until the facility submits acceptable Plans of Correction and Evidence of Corrections for all cited deficiencies. However, when a standard refers to "*appropriate*," "*proper*," or "*adequate*", reasonable flexibility and room for consideration by the surveyor is permitted as long as patient and staff safety remain uncompromised.

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ANESTHESIA CLASS REQUIREMENTS

If a facility is not in compliance with any item in this document, standard 1-A-1 will be scored as deficient.

All facilities must comply with the laws, regulations, and professional scope-of-practice requirements of their specific country or state regarding who may administer sedation and anesthesia. QUAD A acknowledges that not every licensed provider listed below will be applicable to all facilities. It is the facility's responsibility to understand and follow its jurisdiction's legal and regulatory requirements, as well as the scope-of-practice for each licensed provider working within the facility. When requirements differ, the more stringent requirement must be followed as long as it does not conflict with state or country law.

1. Class A (Facility must meet every Class "A" requirement):

All surgical and procedural cases are performed in the facility under local, topical anesthesia, minimal sedation, or nitrous oxide using a standalone system for administration.

NOTE: Endotracheal tubes and supraglottic airways are permitted in the facility for emergency use only.

Local or Topical Anesthesia may be administered by any of the following:

- Surgeon/Proceduralist
- Physician Anesthesiologist
- Dental Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA) under the supervision of an anesthesiologist
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Registered Nurse (RN) under the direct supervision of a credentialed physician as permitted by state law.

Nitrous Oxide may be administered using a Nitrous-Oxide Delivery System with required safety features by a credentialed:

- Surgeon/Proceduralist
- Physician Anesthesiologist
- Pediatric Dentist
- Dental Anesthesiologist
- Oral and Maxillofacial Surgeon (OMS)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA)
- Dental Assistant under the supervision of a Pediatric Dentist or Dental Anesthesiologist in accordance with State law.

- Registered Nurse, Nurse Practitioner, or Physician Assistant under the direct supervision of a credentialed physician as permitted by state law.

Anxiolytics may be administered for mild sedation by any of the following:

- Surgeon/Proceduralist
- Physician Anesthesiologist
- Dental Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA) under the supervision of an anesthesiologist
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Registered Nurse (RN) with an electronic or written order by a credentialed provider.

Clarifications:

- All cases performed in a Class A facility must be performed using local anesthesia with minimal sedation only. A Class A facility is not permitted to perform any cases with moderate sedation.
- No more than 500cc of liposuction aspirate may be removed.
- A single dose of analgesic or minimal sedation (anxiolytic) drug may be administered preoperatively, which results in minimal sedation, and one (1) dose of the same medication may be administered postoperatively. Any additional doses or agents are considered Moderate Sedation, requiring the facility to be accredited under **facility Class B, C-M (international facilities only)**, or C standards. This includes doses taken by patients prior to arriving at the facility.
- The use of propofol, spinal anesthesia, epidural anesthesia, endotracheal intubation anesthesia, laryngeal mask airway anesthesia, and/or inhalation general anesthesia (excluding nitrous oxide) is prohibited.
- **The combination of Nitrous Oxide and any agent that results in minimal sedation is not permitted to be administered together in a Class A facility; they are only permitted in facility Class B, C-M (international facilities only), and C facilities.**
- If a facility performs procedures by administering oral **anxiolytics** (e.g., **diazepam**) **in conjunction with** performing **major peripheral or plexus** nerve blocks (**interscalene**, **supraclavicular**, **femoral**) **or advanced regional techniques** (e.g., **retrobulbar block**, **digital**, **Bier block**.), this practice **falls under the accreditation standard for facility Class B**. The use of field or nerve blocks is **not** permitted in facilities accredited under facility Class A accreditation standards. Digital blocks are permitted in Class A.
- **Exception: Simple local infiltration anesthesia, including digital nerve blocks, is permitted under the accreditation standard for facility Class A.**

2. Class B (Facility must meet every Class “A” and “B” requirement):

Surgical and procedural cases are performed in the facility under intravenous sedation, regional anesthesia, analgesia, or dissociative drugs (excluding Propofol), **that result** in moderate (**formerly referred to as** conscious sedation) and without the use of endotracheal intubation or laryngeal mask airway, or inhalation general anesthesia. The use of sublingual midazolam, ketamine HCl, and ondansetron (MKO) melt is permitted.

NOTE: Endotracheal tubes and supraglottic airways are permitted in the facility for emergency use only.

Intravenous Sedation may be administered by any of the following:

- Surgeon/proceduralist
- Physician Anesthesiologist
- Dental Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA)
- Registered Nurse, Nurse Practitioner, or Physician Assistant under the direct supervision of a qualified physician

Field and Peripheral Nerve Blocks may be administered by any of the following:

- Physician Anesthesiologist
- Oral and Maxillofacial Surgeon (OMS)
- Dental Anesthesiologist
- Pediatric Dentist
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA)

Oral or Intranasal Sedation may be administered by any of the following:

- Surgeon/Proceduralist
- Physician Anesthesiologist
- Dental Anesthesiologist
- Pediatric Dentist
- Oral Maxillofacial Surgeon (OMS)
- Certified Anesthesia Assistant (CAA)
- Certified Registered Nurse Anesthetist (CRNA)
- Registered Nurse, Nurse Practitioner (NP), or Physician Assistant (PA) under the direct supervision of a qualified physician

The use of propofol, spinal anesthesia, epidural anesthesia, endotracheal intubation anesthesia, laryngeal mask airway anesthesia, and/or inhalation general anesthesia (excluding nitrous oxide) is prohibited.

3. **Class C-M:** (A Facility must meet every Class “A” and “B” accreditation standard requirement): Class C-M is an accreditation pathway available only to international facilities.

Surgical and procedural cases are performed in the facility under moderate or deep sedation, **including the use of Propofol, Epidural, or Spinal anesthesia.**

The use of endotracheal intubation anesthesia, laryngeal mask airway anesthesia, and/or inhalation general anesthesia (excluding nitrous oxide) is prohibited.

Propofol may be administered by any of the following:

- Physician Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA)

Epidural Anesthesia may be administered by any of the following:

- Physician Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA)

Spinal Anesthesia may be administered by any of the following:

- Physician Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA)

Dissociative Drugs may be administered by any of the following:

- Physician Anesthesiologist
- Certified Anesthesia Assistant (CAA)
- Certified Registered Nurse Anesthetist (CRNA)
- Registered Nurse, Nurse Practitioner (NP), or Physician Assistant (PA) under the direct supervision of a qualified physician.

Clarification:

- The use of endotracheal intubation anesthesia, laryngeal mask airway anesthesia, and/or inhalation general anesthesia (excluding nitrous oxide) is prohibited.
4. **Class C:** (A Facility must meet every Class “A”, “B” “C-M” (international facilities only), and “C” requirement):

Surgical and procedural cases may be performed in the facility with intravenous propofol, spinal or epidural, and general anesthesia administered by any of the following:

- Physician Anesthesiologist
- Dental Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesia Assistant (CAA)

Clarifications:

- Facilities using total intravenous anesthesia (TIVA) and have no inhalational anesthetics present in the facility would not be required to have an anesthesia machine. See standard 4-C-18.
- **For International Facilities:** Achieving Class C accreditation requires full compliance with all Class C standards, including those for general anesthesia with an anesthesia machine, in addition to all requirements for Classes A, B, and C-M.

Additional Guidance

Table 1. ASA Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2019

	Minimal Sedation (Anxiolysis)	Moderate Sedation/Analgesia (Conscious Sedation)	Deep Sedation/Analgesia	General Anesthesia
Responsiveness	Normal response to verbal stimulation	Purposeful* response to verbal or tactile stimulation	Purposeful* response after repeated or painful stimulation	Unarousable, even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular function	Unaffected	Usually maintained	Usually maintained	May be impaired

Minimal Sedation (Anxiolysis) indicates a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Moderate Sedation/Analgesia (Conscious Sedation) indicates a drug-induced depression of consciousness during which patients respond purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully* after repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia (Conscious Sedation) should be able to rescue patients who enter a state of Deep Sedation/Analgesia, whereas those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia. (Developed by the American Society of Anesthesiologists: Approved by ASA House of Delegates on October 13, 1999 and last amended on October 15, 2014. Available at: <http://www.asahq.org/quality-and-practice-management/practice-guidance-resource-documents/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedation-analgesia>. Accessed on August 21, 2017.)

*Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

Patient Monitoring – Moderate and Deep Sedation

Many of the complications associated with moderate sedation and analgesia may be avoided if adverse drug responses are detected and treated in a timely manner (*i.e.*, before the development of cardiovascular decompensation or cerebral hypoxia). Patients given sedatives or analgesics in unmonitored settings may be at increased risk of these complications.

Patient monitoring includes strategies for the following: (1) monitoring patient level of consciousness assessed by the response of patients, including spoken responses to commands or other forms of bidirectional communication during procedures performed with moderate sedation/analgesia; (2) monitoring patient ventilation and oxygenation, including ventilatory function, by observation of qualitative clinical signs, end-tidal carbon monoxide, and pulse oximetry; (3) hemodynamic monitoring, including blood pressure, heart rate, and electrocardiography; (4) contemporaneous recording of monitored parameters; and (5) availability/presence of an individual responsible for patient monitoring. See standards in Section 8: Clinical Records, Sub-section H.

Summary Table for Anesthesia Options

ANESTHESIA OPTIONS	Class			
	A	B	C-M*	C
Local Anesthesia	X	X	X	X
Topical Anesthesia	X	X	X	X
Nitrous Oxide	X	X	X	X
Parenteral Sedation		X	X	X
Field and Peripheral Nerve Blocks		X	X	X
Dissociative Drugs (excluding Propofol)		X	X	X
Propofol			X	X
Epidural Anesthesia			X	X
Spinal Anesthesia			X	X
General Anesthesia – with or without endotracheal intubation anesthesia, or laryngeal mask airway (LMA) anesthesia				X

***Applicability Note:** Class C-M is an accreditation pathway available only to International Facilities

Nitrous Oxide

Only Nitrous Oxide-Oxygen Delivery Systems with the following safety features may be used in a QUAD A accredited facility:

- Alarms - Audio and/or visual alarms (e.g., low- or high-oxygen and nitrous oxide pressure alarms).
- Color Coding - Gas tanks, knobs, and hoses are coded by color (standardized nationally, but not necessarily internationally).
- Diameter index safety system - A standard for noninterchangeable, removable connections for use with medical gases helps ensure that the appropriate gas flows through the appropriate tubing and cannot be interchanged.
- Emergency air inlet - An inlet designed to remain closed as long as gases are being administered to the patient; however, when the oxygen fail-safe system turns the gases off, ambient air is allowed to enter the system so that the patient can continue to breathe through the nasal hood or face mask.
- Locks - According to national fire codes, nitrous oxide and other compressed gases must be kept in locked rooms; many manufacturers supply additional locks for the machines at the tanks, the manifold, or the mixer level to prevent staff members from accessing nitrous oxide inappropriately.
- Oxygen fail-safe system—The oxygen fail-safe system is designed so that the nitrous oxide supply will be turned off automatically when oxygen delivery is compromised or depleted. Delivery systems are required to provide a minimum oxygen liter flow that ensures 2.5 to 3.0 liters of oxygen per minute is the minimum amount being administered and that concentrations of oxygen never fall below 30% during gas delivery.
- Oxygen flush button—This mechanism allows 100% oxygen to be administered through a reservoir bag in the event of an emergency. When the button is pressed, the oxygen flush valve engages, and the system delivers oxygen straight from the pipeline or tank regulator at 45 to 50 psi at a flow rate between 35 and 75 L/min.
- Pin-index safety system—Pins protruding from the gas tank yokes have a unique configuration that fits into corresponding holes in the tank valves. This helps prevent the accidental attachment of a nonoxygen tank to the oxygen attachment portal.
- Quick connect for positive-pressure oxygen- In an emergency situation in which positive-pressure oxygen is required (e.g., to augment cardiopulmonary resuscitation), quick-connect compatibility helps ensure immediate access to positive-pressure oxygen anywhere in the office.
- Reservoir bag—An inflatable rubber reservoir bladder into which fresh gas entering the circuit is conveyed; the bag is filled gradually as gases enter the circuit and deflates with inhalation.

SECTION 1: BASIC MANDATES

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section A: Anesthesia Options							
1-A-1	A	B	C-M	C	The facility practices within the Anesthesia Class for which it is accredited and in accordance with facility policies and procedures, industry standards, regulations, and laws governing the facility.		Verify the facility operates within its accredited anesthesia class (A, B, C-M (international only) or C). (See Anesthesia Class Definitions & Requirements) Evaluating Compliance: Review policies for required staff qualifications (surgeons, anesthesia providers, and RNs performing moderate sedation) Interview staff regarding the type of sedation and/or anesthesia administered (and by whom) Confirm the facility is operating within the correct anesthesia class; consult QUAD A if uncertain Review clinical records and surgical logs for elements relevant to anesthesia level/authorized staff Review personnel files to validate staff credentials and training Non-anesthesia staff (both physicians and RNs) delivering moderate sedation should have evidence of training and competency.
1-A-2	A	B	C-M	C	All care is provided by a credentialed healthcare provider as listed in the Anesthesia Class document and in accordance with facility policies, procedures, and state/provincial and federal law.		Please see the Anesthesia Class Definitions & Requirements document for and References
Sub-section B: Basic Mandates							
1-B-3	A	B	C-M	C	The facility has defined a mission statement that reflects the population it serves and the services it provides.		Verify the facility's mission statement clearly defines what it wants to achieve at the highest level for its patients/service users. Evaluating Compliance: Review the facility's mission statement Interview leadership and staff regarding its implementation.
1-B-4	A	B	C-M	C	The facility has provided a set of organizational values which guide daily operations, are familiar to all staff, and are available to the public.		Verify the facility's values clearly define how the facility provides its services.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							<u>Evaluating Compliance:</u> Review the facility's values Interview leadership and staff regarding its implementation.
1-B-5	A	B	C-M	C	The facility must inform the public of the services.		Verify the facility has clearly communicated its available services to the public. <u>Evaluating Compliance:</u> Review public notices (e.g., website, brochures) to ensure they are consistent with services provided.
1-B-6	A	B	C-M	C	The facility must ensure that no marketing and advertising regarding the competence and capabilities of the organization is misleading or implies that it provides care or services that it is not capable of providing.		Verify the organization's marketing materials truthfully represent its service capabilities and competencies. <u>Evaluating Compliance:</u> Review documents with marketing/advertising content with facility leadership Confirm whether representations align with actual services and capabilities.
1-B-7	A	B	C-M	C	Only recognized abbreviations are allowed to be used in the clinical record.		Verify the facility promotes patient safety by using only approved medical abbreviations for consistency in clinical records. The facility may adopt a recognized reference (e.g., MedicineNet, Taber's) or create its own approved list. <u>Evaluating Compliance:</u> Review policies for the official list of approved abbreviations (external reference or internal policy) Confirm that abbreviations used in clinical records align with the approved list.
1-B-8	A	B	C-M	C	The facility must perform a self-survey review of compliance with all QUAD A standards annually prior to the expiration date of its accreditation in each of the two years between QUAD A onsite surveys. The self-survey documentation must be retained for a minimum of 3 years and include: 1. A completed Self-Survey checklist 2. A Plan of Correction for any standard identified as non-compliant 3. Evidence that each plan of correction has been		Verify the facility performs annual self-surveys, documents non-compliance, and takes corrective actions to maintain compliance with QUAD A standards . <u>Evaluating Compliance:</u> Review documents for evidence that the most recent self-survey includes all required elements Confirm availability of self-surveys from the past three (3) years.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
					carried out to establish compliance with standards 4. Evidence that findings from the self-survey have been reviewed, included in the facility's Quality Improvement Plan, and discussed in the facility's Quality Improvement meetings.		
1-B-9	A	B	C-M	C	The facility must make its final survey results publicly available.		Verify that the facility's final survey results are accessible to the public. Evaluating Compliance: Confirm the method(s) of public disclosure (e.g., posted on website, certificate displayed in facility).
Sub-section C: Patient Selection							
1-C-1	A	B	C-M	C	A patient who, by reason of pre-existing or other medical conditions, is at significant risk for outpatient surgery in this facility must be referred to alternative facilities as defined in facility policy. Any surgery for which a patient must be routinely transferred to a hospital after the surgery is not appropriate for an outpatient surgical setting.		Verify the facility refers high-risk patients to alternative facilities. ASA Class IV patients are allowed for vascular and ophthalmic procedures that are commonly performed in the outpatient setting. Evaluating Compliance: Review policies for: Identified patient risk categories Any exemptions for high-risk patients having vascular/ophthalmic procedures common to outpatient setting Medical clearance requirements Patient acceptance/referral criteria for scheduling at the facility Interview staff about scheduling protocols and incidence of routine hospital transfer Review clinical records for compliance with facility policy.
1-C-2	A	B	C-M	C	The facility must have a scheduling policy that includes only those procedures and/or a combination of procedures of duration and degree that permit safe recovery and discharge from the facility consistent with federal/national, state/provincial, and local regulations, if applicable.		Verify the facility maintains a scheduling policy consistent with applicable regulations. Some states and countries put time limits on outpatient surgery, but general recommendations are limits of up to six (6) hours for a general anesthesia case. The stricter requirement prevails. The total patient time in the facility must not exceed 23 hours 59 minutes, during which staffing minimums must be maintained and a physician must be immediately available. Evaluating Compliance: Review policies for: A list of approved procedures/combination of procedures allowed to permit safe recovery and discharge

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Surgical time limit and the methodology to determine length (e.g., open-close time, time in/time out, anesthesia time) Patient stay must not exceed 23 hours 59 minutes Physician availability until patient discharge References to any applicable federal, national, state, or local regulations and directives to comply Review clinical records for compliance with surgical time limits and incidence of routine hospital transfer.
1-C-3	A	B	C-M	C	The process for entry or admission to the facility for a procedure must be coordinated and defined in a policy.		Verify the facility has an approved patient admission and registration processes to coordinate care delivery. <u>Evaluating Compliance:</u> Review policies for defined procedures to admit the patient to services and care coordination mechanisms Review documents for consistency with policies Interview staff about process implementation and the understanding of registration workflow Observe processes in practice (when possible).
1-C-4	A	B	C-M	C	If pediatric services are provided by the facility, there must be a written policy defining the unique perioperative care of pediatric patients. This is based upon considerations of age, BMI or weight, special needs, risk categories, surgery, facility equipment, and capability. The written policy for pediatric patients is available and current.		Verify the facility has a comprehensive pediatric care policy that defines parameters and individualized care considerations to address perioperative needs based on: Physical, psychosocial, developmental, safety, and other special needs Risk categories Procedure types Specialized equipment and medications Staff competency There is a recommendation against arbitrary age limits, as disability rights may accompany patients through young adulthood when appropriate. Parameters defining pediatric care should be in accordance with industry standards and those of the local jurisdiction having authority. <u>Evaluating Compliance:</u> Review policies for: Alignment with state/national law regarding chronological age

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							(when applicable) Pediatric parameters Approved procedures Safety, emergency, and transfer protocols Interview staff regarding pediatric risk categories and emergency preparedness procedures Review personnel records for evidence of competency Confirm the presence of age-appropriate equipment, medications, and supplies.
1-C-5		B	C-M	C	No more than 5000 mLs of aspirate may be removed while performing liposuction in a Class B or C facility.		Verify the facility restricts total liposuction aspirate to $\leq 5,000$ mL to reduce the risk of fluid shifts. Evaluating Compliance: Interview staff regarding adherence to $\leq 5,000$ mL volume limit and what occurs when the total has been exceeded Review clinical records: Include $\geq$ one (1) liposuction case to confirm compliance with aspirate limit Review any cases where exceeding 5,000 mL limit was reported as an adverse event.
1-C-6	A				No more than 500 mLs of aspirate should be removed when performing liposuction in Class A facilities. The more stringent requirement applies if State law differs.		Verify the Class A facility restricts total liposuction aspirate to ≤ 500 mL. Evaluating Compliance: Interview staff regarding any cases where ≤ 500 mL total aspirate has been exceeded. Review clinical records: Include $\geq$ one (1) liposuction case to confirm compliance with aspirate limit Review any cases where > 500 mL was reported as an adverse event.
Sub-section D: Patients' Rights							
1-D-1	A	B	C-M	C	A copy of the most current QUAD A "Patients' Bill of Rights" is prominently displayed, or a copy is provided to each patient. The QUAD A "Patients' Bill of Rights" is also adhered to by facility personnel. If required, an additional Patients' Bill of Rights must be prominently displayed in accordance with prevailing laws and regulations.		Verify the facility informs patients of their rights in writing by posting the QUAD A Bill of Rights (and any other patient rights document adopted by the Governing Body). The document(s) must be either displayed in a public area or provided to the patient at registration. Evaluating Compliance:

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Confirm the Bill or Rights document(s) are publicly displayed or provided to the patient (or responsible adult) in writing upon admission.
1-D-18	A	B	C-M	C	The patient has a right to personal privacy.		Verify that the underlying principle of this requirement is the patient's basic right to respect, dignity, and comfort. "The right to personal privacy" includes at a minimum, that patients have privacy during personal hygiene activities (e.g., toileting, dressing), during procedures/surgeries, and when requested as appropriate. People not involved in the care of the patient should not be present without the patient's consent while the patient is being examined or treated. Video or other electronic monitoring or recording methods should not be used when the patient is being examined without the patient's consent. If a patient requires assistance during toileting and other personal hygiene activities, staff should assist, giving the utmost attention to the patient's need for privacy. Privacy should also be afforded when staff visits the patient to discuss clinical care issues or conduct any examination. A patient's right to privacy may be limited in situations where a person must be continuously observed, such as when there is an emergency and transfer to a hospital is pending. <u>Evaluating Compliance:</u> Observe: How staff provide patient privacy What safeguards are in place to protect patient privacy (e.g., privacy curtains, secured workstations, patient identifiers on white board, etc.) Interview staff on: How they provide patient privacy What staff education is provided on patient privacy.
1-D-19	A	B	C-M	C	The patient has a right to receive care in a safe setting.		Verify that each patient is receiving care in an environment that a reasonable person would consider to be safe. The facility staff should follow current standards of practice for patient environmental safety, infection control, and security. The facility staff should also provide protection for the patient's emotional health and safety, such as respect, dignity, and comfort, as well as the patient's physical safety. <u>Evaluating Compliance:</u> Review PSDR submissions to identify any incident patterns concerning

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							a safe environment Review infection control and QAPI documentation to determine if the facility is identifying problems, evaluating them, and taking steps to ensure a safe environment. Observe the environment Interview staff and patients to see if there are any concerns about safety.
1-D-20	A	B	C-M	C	The patient has a right to be free from all forms of abuse or harassment.		Verify the facility is prohibiting all forms of abuse, neglect (as a form of abuse), and harassment from staff, other patients, or visitors. The facility must have mechanisms/methods in place ensure that patients are free from all forms of abuse, neglect, or harassment. <u>Evaluating Compliance:</u> Review policies for inclusion of investigating allegations of abuse and neglect, reporting, and staff training Interview staff to determine if they know what to do if they witness abuse and what training that they have had.
1-D-22	A	B	C-M	C	The patient has a right to refuse treatment.		Verify the facility informs patients of their right to receive complete health information, participate in care decisions, and refuse care (with legally permitted exceptions). Facility policies must include key exceptions for: Minors Patients lacking mental capacity Life-threatening conditions Public health risks (e.g., infectious diseases) In these cases, guardians may exercise refusal rights. <u>Evaluating Compliance:</u> Review facility policy for treatment refusal provisions and exception protocols Review the Patient Rights document(s) for inclusion of verbiage for treatment refusal and exceptions Interview staff about the refusal processes Review any clinical records involving treatment refusals and advance directives or power of attorney with guardian involvement.
1-D-23	A	B	C-M	C	All new staff must have training regarding the Patient Bill of Rights including concerns and complaints from family members / adult escorts and the various religious and		Verify staff providing care services have received education that supports the delivery of compassionate, person-centered care which respects patients'/service users' rights., including:

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
					ethnic concerns of the usual patient population and the policy and process for addressing concerns and complaints.		Respecting patients' rights Respecting patient privacy and dignity Communication skills Shared decision making Understanding what matters & is most important in their care Understanding & respect for different beliefs, customs, and traditions Addressing patient concerns Process for addressing/resolving concerns and complaints. Education may be provided by the facility or by external providers. <u>Evaluating Compliance:</u> Review policies for procedures addressing patient concerns and complaints Review facility documents (i.e., complaint logs, Governing Body meeting minutes) for evidence of complaints and their resolution Interview staff regarding patient rights and the facility's complaint process Review personnel records for evidence of training (initial, updates).
1-D-24	A	B	C-M	C	Any issues judged significant related to the Patient's Bill of Rights must be brought to the attention of administration in a timely fashion.		Verify the staff understands the types of patient rights concerns that require escalation. <u>Evaluating Compliance:</u> Review policies for: Concerns that require escalation and investigation (e.g., abuse, discrimination) Timeframe for response to complainant Directive to comply with any mandated reporting (e.g., abuse) Review facility documents (i.e., logs, Governing Body meeting minutes) regarding accommodations, escalations, and reporting Interview staff regarding which issues require escalation.
1-D-25	A	B	C-M	C	The facility must have the patient acknowledge that the Bill of Rights has been reviewed and understood by the patient/legal representative.		Verify the facility effectively communicates the Patient's Bill of Rights by: Providing clear explanations and Q&A opportunities Offering translated versions/interpreters for non-native speakers <u>Evaluating Compliance:</u> Observe process for how staff explains the Patient's Bill of Rights Review clinical records for signed patient acknowledgments and documentation of language assistance (if applicable)

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
1-D-26	A	B	C-M	C	The facility must provide patient privacy including gender-specific dressing and lavatory areas. This may include gender-specific dressing and lavatory areas as well as dietary provisions if provided by the facility.		Verify the facility protects patient privacy by: - Securing personal information - Providing gender-specific changing areas and restrooms - Accommodating special needs (e.g., dietary restrictions). Evaluating Compliance: Review policies to confirm privacy protocols exist for: - Facility design - Special accommodations Interview staff regarding privacy practices Observe compliance during delivery of patient care Confirm dressing/restroom areas have gender-specific designations and proper signage.
1-D-27	A	B	C-M	C	The staff provide care in a manner that is respectful, professional, and consistent with the facility's mission statement.		Verify staff demonstrate professional conduct in all patient and family interactions, in accordance with the mission statement Evaluating Compliance: Interview patients/families about their experience at the facility Observe staff interactions with patients/families
1-D-28	A	B	C-M	C	The Patient's Bill of Rights is printed and available in the language of the majority (and substantial minority) of the patient population served.		Verify the facility's Patient's Bill of Rights is: - Written in plain language - Available in the main patient languages (e.g., Arabic, English, Spanish, etc.) - Accessible via posting and/or direct distribution. Evaluating Compliance: Review policies for requirement of language accommodations and which languages were selected for translation Interview staff regarding the facility's distribution process and their language accommodation procedures Confirm the Patient's Bill of Rights is printed in the prominent languages of the populations served.
Sub-section E: QUAD A-Mandated Reporting							
1-E-1	A	B	C-M	C	Changes in facility ownership must be reported to the QUAD A Central Office within thirty (30) days of the change.		Verify QUAD A records accurately reflect current facility ownership. Evaluating Compliance: Interview leadership regarding current ownership Review facility documents to confirm QUAD A records were updated if

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							a change in ownership occurred. If there were no changes in ownership, mark as compliant.
1-E-2	A	B	C-M	C	Any change in provider staff must be reported to the QUAD A Central Office, in writing, within thirty (30) days of the change, along with the appropriate credentials. Surgical Programs (ASC, OBS, OBP, PD, OMS, I-DENT, I-SURG): Surgeons, Proceduralists, and Pain Management Providers must submit medical license, board certification or board eligibility, and delineation of facility privileges. RHC: Physicians, Advanced Practice Providers (NP, PA, CNM) and licensed behavior health providers (CP, CSW, MFT, MHC) must submit professional licenses. Physical Therapy (OPT, I-PT): SLP, OT, PT, SLPA, OTA, PTA must submit professional licenses. Polyclinic: Physicians, Dentist, Advanced Practice Providers (NP, PA, CNM), Physiotherapist, and Physical Therapists must submit must professional licenses.		Verify QUAD A records accurately reflect the licensed providers performing procedures, treatments, or furnishing patient care services in the facility. Evaluating Compliance: Review documents and credentialing/personnel files to confirm the list of licensed providers performing surgery, procedures (excluding those solely providing surgical anesthesia services), treatments, or furnishing patient care services. If changes have occurred, confirm timely reporting to QUAD A within 30 days.
1-E-3	A	B	C-M	C	Any action affecting the current professional license of any licensed facility staff must be reported in writing to the QUAD A office within ten (10) days of the time the facility becomes aware of such action.		Verify the facility reports to QUAD A any adverse licensure actions (e.g., suspension, probation, revocation, practice restrictions/limitations, etc.) of any professionally licensed staff working in the facility. Evaluating Compliance: Review credentialing files for active license status and documentation of adverse actions If present, confirm timely reporting to QUAD A within 30 days Interview staff regarding monitoring procedures and reporting protocols for adverse licensure actions.
1-E-4	A	B	C-M	C	Any death occurring in an accredited facility or any death occurring within thirty (30) days of a procedure performed in an accredited facility must be reported to the QUAD A office within five (5) business days after the facility is notified or otherwise becomes aware of that death. In addition to this notification, the death must be contemporaneously reported as an adverse event in the		Verify the facility reports to QUAD A all patient deaths (occurring on the day of the procedure or within thirty (30) days of the procedure) within five (5) days after being notified.. Evaluating Compliance: Interview staff regarding any qualifying patient deaths occurring since the date of the last survey

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
					online Patient Safety Data Reporting portal. In the event of a death occurring within thirty (30) days of a procedure performed in an QUAD A-accredited facility, an unannounced survey may be performed.		Review any qualifying patient deaths in the clinical record sample If applicable, verify timely reporting via the PSDR portal.
1-E-5	A	B	C-M	C	All adverse events which occur in the facility or as a result of care provided at the facility must be communicated to the affected patient(s) and/or facility staff.		Verify the facility discloses adverse events to patients (and facility staff) to ensure patients understand any implications to their health status and to support a robust culture of safety. Evidence of Compliance: Review policies for a directive to disclose adverse events (e.g., medication errors, wrong site surgery) to patients and the Governing Body (GB) Interview quality coordinator regarding: Procedures for communicating adverse events to patients (or responsible adults) Request evidence of disclosures to facility staff (e.g., GB meeting minutes) (if applicable) Request clinical records from any adverse events reported in the past year to confirm the disclosure was reported to the patient (or responsible adult).
Sub-section F: Patient Safety Data Reporting (PSDR)							
1-F-1	A	B	C-M	C	Online Patient Safety Data Reporting is performed at least every three (3) months in accordance with the due dates established by QUAD A and includes submitting random cases and all adverse events to the QUAD A portal at www.QUAD A.org .		Verify the facility complies with PSDR reporting standards for random cases and adverse events and meets quarterly reporting deadlines. Evaluating Compliance: Review documents for submission to PSDR and inclusion in Governing Body minutes Interview Quality Coordinator about random case(s) submission, adverse event reporting and compliance with quarterly deadlines: Q1 Jan 1-Mar 30 Apr 15 Q2 Apr 1-Jun 30 Jul 15 Q3 Jul 1-Sep 30 Oct 15 Q4 Oct 1-Dec 31 Jan 15.
1-F-2	A	B	C-M	C	For each surgeon/proceduralist operating in the facility, the random sample of case must include the first case performed by such surgeon/proceduralist each month during the reporting period. The facility must submit into the online Patient Safety Data Reporting portal a minimum of three (3) cases, or all cases performed by surgeons		Verify the facility complies with the PSDR reporting standard (1-F-2) for random cases. Evaluating Compliance: Review documents and cross-reference the first monthly case (by each physician) from the procedure log to PSDR submissions (or

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
					who have performed fewer than three (3) in the respective period, every three (3) months. If a surgeon/proceduralist performed fewer than three (3) cases, an exemption form must be submitted.		exemptions) during the reporting period for the past twelve (12) months Confirm documentation of physician peer review exists for each random case selected Interview the Quality Coordinator re: the random case selection process.
1-F-3	A	B	C-M	C	The facility is up to date with accurate PSDR reporting. Reportable adverse events must be submitted to PSDR, including, but not limited to: · Any unplanned hospital admission; · Any emergency department visit; · Any unscheduled return to the operating room for a complication of a previous surgery; · Any complication such as infection, bleeding, wound dehiscence, or inadvertent injury to another body structure; · Any cardiac or respiratory problems during the patient's stay at the facility or within 48 hours of discharge; · Any allergic reactions · Any pre- and post-procedure incorrect instrument, needle or sponge counts · Any patient or family complaint; · Any equipment malfunction leading to injury or potential injury to the patient; · Any death occurring within 30 days of a procedure; · Any iatrogenic dental trauma		Verify the facility complies with adverse event submissions into PSDR. <u>Evaluating Compliance:</u> Review policies for definitions of adverse events, internal investigation process, and inclusion of QUAD A mandated reporting requirements (Section 1: Sub-Sections E & F) Interview the Quality Coordinator about adverse event reporting, investigations, and timeframes Cross-reference any adverse events to evidence of PSDR submissions for the past twelve (12) months Confirm physician peer review exists for each adverse event, and such events appear in Quality program documents and Governing Body minutes.
1-F-15	A	B	C-M	C	Each adverse event submission must include: · The identification of the problem, · The immediate treatment or disposition of the case, · The outcome, · The reason for the problem, and · An assessment of the efficacy of treatment.		Confirm the facility complies with adverse event submissions. <u>Evaluating Compliance:</u> Review facility documentation for evidence of adverse event reporting Cross-reference any adverse events to evidence of PSDR submissions for the past twelve (12) months.

SECTION 2: FACILITY LAYOUT & ENVIRONMENT

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section A: Layout							
2-A-1		B	C-M	C	The Operating Suite is physically and distinctly separate and segregated from the General Office Area (waiting room, exam room(s), administrative area, physician office, staff lounge, etc.)		Verify there is a physical separation between the Operating Suite and other areas within the facility. Evaluating Compliance: Inspect the facility layout for separations or barriers that minimize opportunities for cross-contamination Compare the layout with the floor plan submitted to QUAD A.
2-A-2		B	C-M	C	The Operating Suite includes the Operating Room, Prep/Scrub area, Clean and/or Dirty Room, and Post-Anesthesia Care Unit (PACU).		Verify the facility maintains the distinct areas required within the Operating Suite. Evaluating Compliance: Interview staff to determine where major procedures may be performed Inspect the facility layout for all required components.
2-A-3		B	C-M	C	There is a separate and adequately sized Post-Anesthesia Care Unit (PACU) within the operating room suite.		Verify the facility maintains a separate and adequately sized PACU within the Operating Suite. The PACU may also be used for preoperative preparation of patients as well as for post-operative recovery, consistent with accepted standards of practice. Under no circumstances, however, may the PACU also be used as a general waiting area for patients awaiting preoperative preparation or for people who accompany patients. Evaluating Compliance: Inspect the PACU to verify it: Meets structural requirements (full-height walls, barriers for protecting privacy) separating it from other areas of the facility Equipped to allow appropriate monitoring of the patient's recovery Confirm the size is appropriate for the number of operating rooms and the expected volume of patients in recovery simultaneously.
2-A-7		B	C-M	C	All major surgery is done in the separate and distinct operating room(s).		Verify that major surgeries are only performed in fully equipped operating rooms. Major surgery includes any of the following: Body cavity entry

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Mesenchymal barrier crossing Fascial plane opening Organ removal Anatomic alteration. Evaluating Compliance: Review clinical records & surgical log for procedure locations Interview staff about major surgery criteria and approved procedure locations Confirm the operating rooms are appropriately equipped.
2-A-8		B	C-M	C	Unauthorized individuals are deterred from entering the operating room suite either by locks, alarms, signage, or facility personnel.		Verify the facility maintains strict access control to the Operating Suite. Evaluating Compliance: Review policies for access restrictions and staff credentialing requirements Interview staff about authorized personnel, monitoring systems, barriers, and security measures Observe for sign "Authorized Personnel Only" and/or security measures (locks, alarms) Confirm compliance with access protocols at Operating Suite entry points.
2-A-9	A	B	C-M	C	There is a separate waiting room which is adequately sized and adequately lighted.		Verify the facility maintains a waiting room appropriate to the population served and for guests. Evaluating Compliance: Confirm there is a separate area where patients and guests have adequate seating and light furnishings,
2-A-10	A	B	C-M	C	There is designated area for administrative activities.		Verify the facility maintains an area for administrative operations. Evaluating Compliance: Confirm there is a separate, administrative area that allows for administrative work.
2-A-11	A	B	C-M	C	There is at least one examination room.		Verify there is an area for patient examination. Evaluating Compliance: Confirm at least one (1) separate examination room.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
2-A-12	A	B	C-M	C	This examination room is separate and distinct from the operating room.		Verify there is an area for patient examination. <u>Evaluating Compliance:</u> Confirm that a patient exam room is available outside of the Operating Suite.
Sub-section B: Facility Environment							
2-B-3	A	B	C-M	C	The entire facility must be maintained, equipped, regularly cleaned, sanitary, and free of clutter and litter, consistent with a medical facility designed to perform procedures.		Verify the facility maintains cleanliness and implements organizational cleaning and disinfection protocols. <u>Evaluating Compliance:</u> Review policies for cleaning procedures, frequency, and approved disinfectants Interview staff regarding daily cleaning procedures Observe cleaning procedures Visually inspect the facility Confirm facility sanitation and maintenance.
2-B-4	A	B	C-M	C	The walls, cabinets, countertops, blinds and shades, and flooring are covered with smooth and easy-to-clean material that is free from tears, breaks, or cracks. If the floors contain seams or individual tiles, they are sealed with an impermeable sealant other than silicone.		Verify the facility is constructed with materials that allow for easy cleaning/disinfection, as recommended for high-hygiene environments, including: - Use of non-porous, cleanable surface materials - Monolithic OR flooring (see FGI recommendations) - Use of washable materials for curtains/blinds - Carpet use only in non-clinical areas. <u>Evaluating Compliance:</u> Review policies for cleaning protocols and maintenance of surfaces and furnishings Interview staff regarding cleaning techniques and requesting maintenance/replacement Observe facility surfaces and furnishings and confirm appropriate materials and intact finishes.
2-B-5		B	C-M	C	The operating room and scrub area ceiling surface or drop-in tiles are smooth, washable, and free of particulate matter that could contaminate the operating room and scrub area.		Verify the facility minimizes the potential for contamination to the sterile field (or the operating room) originating from overhead surfaces. <u>Evaluating Compliance:</u> Interview staff regarding maintenance protocols regarding operating room ceilings

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Confirm the operating room ceilings do not have evidence of particulate matter, water staining, or gaps in between overhead tiles.
2-B-6	A	B	C-M	C	All openings to outdoor air are effectively protected against the entrance of insects, animals, etc. The facility must have policies and procedures in place and implemented to address these issues.		Verify the facility minimizes the potential for contamination to the environment from air pollutants and pests. Evaluating Compliance: Review policies for adoption of nationally recognized infection prevention and control guidelines, including specific procedures addressing air quality control and pest control Interview staff regarding measures taken to prevent contamination from outside air and pests Confirm the facility does not have gaps in door or window seals, issues with air quality and filtration, or evidence of pests.
2-B-7	A	B	C-M	C	There are no overloaded wall plugs or overloaded extensions in use, no altered grounding plugs in use, and wires are not broken, worn, or unshielded.		Verify the facility addresses electrical safety hazards, including: - Using only UL-certified medical equipment with three-prong grounding - Using only hospital-grade relocatable power taps or power strips (NEMA-5-15P) for multi-device needs - Restricting the use of extension cords - Not used instead of creating permanent wiring solutions - Should not exceed current capacity. Evaluating Compliance: Inspect facility electrical components for: - Proper grounding - UL markings - Non-compliant power strips - Trip Hazards - Extension cords use being temporary (<1 procedure/event) and not powering permanent equipment.
2-B-9	A	B	C-M	C	The entire facility is appropriately lighted, properly ventilated, and temperature controlled for patient and personnel comfort.		Verify the facility environment is adequately maintained for the comfort of patients and others. Evaluating Compliance: Interview staff regarding environmental controls, unresolved issues, and patient complaints Confirm uniform lighting in work areas, functional HVAC systems, and thermostat settings between 68-73° F (20-23° C).

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
2-B-10	A	B	C-M	C	The entire facility provides adequate work space and sufficient space and storage for supplies and equipment.		Verify the facility layout is sufficient and organized to support safe operations, taking into consideration the services provided and the volume of cases performed. Evaluating Compliance: Interview staff regarding the adequacy of space for services and storage, and any workflow challenges Inspect the facility for adequate workspaces and compliant storage conditions (for equipment and supplies).
2-B-14	A	B	C-M	C	The lavatory facilities are sufficient to accommodate patients and staff needs.		Verify the number of bathrooms in the facility meets the needs of patients, guests, and staff. Evaluating Compliance: Interview staff regarding the number of lavatories versus the volume of patients and staff Confirm easy access to lavatories in clinical and non-clinical areas.
2-B-19	A	B	C-M	C	Smoking is prohibited in the entire facility.		Verify smoking is not allowed within the facility. Evaluating Compliance: Review policies for the adoption of a smoking ban Review facility documents to ensure employee handbooks and patient materials reinforce "no smoking" Inspect the facility for posted "No Smoking/Vaping" signs at entrances and key areas Observe for compliance among patients, guests, and staff.
Sub-section C: Operating Room Environment							
2-C-2		B	C-M	C	Each operating room is of a size adequate to allow for the presence of all equipment and personnel necessary for the performance of the operations, and must comply with applicable local, state/provincial or federal/national requirements. There must be ample clear space on each side of the procedure table to accommodate emergency personnel and equipment in case of emergency and permit the safe transfer of the patient to a gurney for transport.		Verify each operating room space is sufficient for safe staff/equipment movement and emergency patient transfers. Evaluating Compliance: Review policies for emergency maneuverability protocols Interview staff regarding knowledge of local space regulations (based on facility business occupancy classification), customized transport techniques for compact operating spaces, or in high-rise buildings Confirm unobstructed pathways and clearance for stretcher movement Request to observe a simulated emergency transfer when adequate space is questionable.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
2-C-3		B	C-M	C	Each operating room is ventilated, temperature and humidity controlled. The facility policy defines parameters based on patient population, procedure, and monitoring frequency in accordance with industry standards.		Verify the operating room environment is maintained, per the facility's policy and procedure, to reduce infection/fire risks and ensure staff/patient comfort. <u>Evaluating Compliance:</u> Review policies for the: Facility's adoption of recognized infection prevention and control guidelines (e.g., CDC, WHO, AORN) Acceptable operating room parameters aligned with the adopted infection prevention and control guidelines, including: Temperature range (e.g., 68-73°F or 20-23°C) Relative humidity range (e.g., 20-60%) Minimum air changes per hour (e.g., 10-12 per hour) Monitoring procedures and frequencies Interview staff regarding process for monitoring and response to out-of-range readings.
2-C-4		B	C-M	C	The facility must have policies and procedures in place that address operating room cleaning, frequency and type of disinfectants used in accordance with industry standards.		Verify that the facility maintains operating room cleaning policies and enacts procedures that align with current infection prevention and control guidelines. <u>Evaluating Compliance:</u> Review policies for: Use of only EPA-approved disinfectants and the protocols for pre/post-procedure cleaning, terminal cleaning, and handling bio-hazardous spills Cleaning frequency Interview staff on cleaning procedures performed by staff and those that are outsourced Review cleaning logs and maintenance logs Inspect the operating room for surface cleanliness, absence of bioburden, and proper equipment storage Review personnel files for evidence of training and competency.
2-C-5		B	C-M	C	There is adequate storage space within the operating room to hold equipment, supplies, and medications. Unused equipment, supplies, and medications are stored in a manner to avoid contamination.		Verify operating room contents are stored according to current infection prevention and control guidelines. <u>Evaluating Compliance:</u> Interview staff regarding the adequacy of supplies or medications stored within the operating room Inspect supplies and equipment stored in the operating room, ensuring:

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Consumables and sterilized instruments are stored in a manner to minimize exposure from surgical smoke, spray, or splatter Any dust cover protecting supplies or equipment is either disposable or may be disinfected in between cases.
2-C-6		B	C-M	C	If a pre-existing sink is present in the operating room, a written policy to prohibit the use of the sink during sterile surgical procedures must be in place. A sink is permissible in an operating/procedure room which is exclusively used for endoscopic or urological procedures in accordance with the standards of those professions. Requests for allowance by other specialties will be reviewed on a case -by-case basis.		Verify the facility prohibits use of a sink during sterile procedures (unless for approved endoscopic/urological cases) to align with current infection prevention and control guidelines. Evaluating Compliance: Review policies regarding sinks and water sources located within the operating room and its alignment with infection prevention and control and/or specialty guidelines Inspect operating room Interview staff regarding protocols for use of water sources in the operating room.
Sub-section D: Post-Anesthesia Care Unit (PACU) Environment							
2-D-1		B	C-M	C	The PACU is maintained, clean and free of litter.		Verify that the facility maintains a sanitary PACU environment in alignment with current infection prevention and control standards. Evaluating Compliance: Review policies regarding cleaning schedules, blood/body fluid spills, and biohazardous waste disposal Interview staff regarding cleaning schedules, use of sharps containers, and pest control measures Inspect the PACU for cleanliness, intact surfaces, visible dust/mold, or evidence of pests or vermin.
Sub-section E: Storage							
2-E-1	A	B	C-M	C	Sterile supplies and equipment are stored away from potential contamination in closed cabinets/drawers; or if not, sterile supplies must be stored away from heavy traffic areas and potential contamination hazards.		Verify the facility maintains the integrity of sterile supplies and equipment. Evaluating Compliance: Review policies for adoption of nationally recognized infection prevention and control guidelines Inspect sterile storage areas for evidence of: Designated, closed storage Elevation of at least 8" from floor Avoidance of high traffic areas

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Compliance with environmental standards for temperature and humidity Prohibiting corrugated cardboard in clean/sterile areas to minimize exposure to dust and pests Prohibiting sterile storage around water sources (only cleaning products in impermeable containers).
2-E-2	A	B	C-M	C	Storage space for sterile supplies and equipment is organized in a manner that maintains cleanliness, sterility, and functionality, provides easy access for identification and minimizes the risk of contamination and injury to patients and staff.		Verify that facility protocols minimize the risks of contamination and injury to patients and staff, ensuring that: Sterile supplies and equipment are stored in a clean, organized, and functional manner Items are easily accessible, protected from contamination Items are arranged to support efficient workflow and inventory management. <u>Evaluating Compliance:</u> Review policies for adoption of nationally recognized infection prevention and control guidelines and inclusion of NFPA 101 requirements. Inspect storage areas for evidence of: Designed, closed storage Cleanliness of storage areas Elevated at least 8" from floor Lowest shelf of wired shelving covered with a plastic cover 18" clearance between fire sprinkler deflectors and the top of storage Avoidance of storage in high traffic areas Compliance with environmental standards for temperature and humidity Prohibiting corrugated cardboard in clean/sterile areas to minimize exposure to dust and pests Prohibiting storage around water sources (only cleaning products in impermeable containers) Confirm operating rooms and corridors have clear pathways.
2-E-3	A	B	C-M	C	As applicable to the setting, outdated medical supplies, instruments, implants, and equipment are removed and destroyed in accordance with federal/national, state, provincial, and local regulations.		Verify the facility complies with the manufacturer's instructions for use (IFU) and expiration dates of supplies and devices to ensure safe use in patient care To maintain sterility or integrity, the facility must: Adhere to the manufacturer's designation for usage (e.g., single-use, reusable)

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Track the number of re-sterilizations (e.g., LMAs, implant sizers) when a limit is defined Maintain set storage requirements (e.g., temperature ranges) When an item does not come with cleaning and re-sterilization instructions, it must be considered a single-use item with a terminal expiration date. It should not be used after the printed manufacturer's expiration date, nor should it be re-sterilized after use. Re-processing "expired" supplies is not acceptable unless this process is documented in the manufacturer's IFU. <u>Evaluating Compliance:</u> Interview staff regarding: Process for determining the manufacturer's designation for use, any items designated for a limited number of re-sterilizations, and process for checking inventory for temperature ranges and expiration dates Review documents tracking the number of times items are re-sterilized (when limited by the IFU) Inspect storage areas and check for expired supplies, medications, or patient care devices Review facility policy.

SECTION 3: SAFETY

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section A: General Safety							
3-A-2	A	B	C-M	C	There is a reliable means of two-way communication to necessary personnel in other facility locations.		Verify the facility maintains a reliable source for secondary communication for emergencies. Evaluating Compliance: Confirm the presence of a backup, two-way communication device Require demonstration of device operation Interview staff regarding: Knowledge of emergency protocols Alternative communication methods.
Sub-section B: Facility Safety Manual							
3-B-1	A	B	C-M	C	There is a Facility Safety Manual that is reviewed and updated annually and is in accordance with all other federal/national, provincial, state and local regulations. For international facilities, there must be evidence that specific national, provincial, and local regulations are included.		Verify that the facility maintains an up-to-date Safety Manual that addresses emergency procedures and the prevention of injuries and illnesses. The facility must ensure staff access to the manual's content. Evaluating Compliance: Review the safety manual for inclusion of: Emergency protocols Safety guidelines Annual review and documented revisions Interview staff regarding: Location of manual Key safety procedures.
3-B-4	A	B	C-M	C	The facility safety manual provides employees with information about hazardous chemicals used and methods to minimize hazards to personnel.		Verify that the facility maintains Hazard Communications resources, including: Complete chemical inventory for the facility Safety Data Sheets (SDS) for all hazardous chemicals formatted using the Global Harmonized System (GHS) Providing employee training on chemical hazards and exposure minimization. Evaluating Compliance: Review the safety manual for the facility's hazardous chemical list and SDS access instructions

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Confirm SDS access (using GHS format) exists for current chemicals inventory Select one random chemical and request the SDS Interview staff regarding workplace chemical hazards and protective measures Review personnel records for evidence of training (initial hazard communication, chemical -specific instruction).
3-B-5	A	B	C-M	C	There is a written exposure control plan, which is reviewed and updated at least annually.		Verify that the facility implements an Exposure Control Plan, including: - Spill/slip/fall prevention - Hazardous material response - Communicable disease response - Providing staff training (initially, with updates). <u>Evaluating Compliance:</u> Review the safety manual for prevention protocols, emergency response procedures, and annual review Interview staff regarding knowledge of hazard response steps and reporting procedures Review personnel records for evidence of training (initial, update acknowledgements).
3-B-6	A	B	C-M	C	There is a written chemical hazard communication program, which is reviewed and updated annually.		Verify the facility implements a Hazard Communication program, including: - Documenting inventory of hazardous materials (updated annually) - Proper labeling in accordance with recognized international standards - Providing readily available access to Safety Data Sheets (SDS) for all hazardous chemicals. - Providing chemical safety training <u>Evaluating Compliance:</u> Review the safety manual for hazardous chemical inventory, SDS index, and annual review Interview staff regarding SDS location for a randomly chosen chemical and safety protocols Confirm chemicals are properly labeled, stored, and appropriately disposed Review personnel records for evidence of training (initial, annually, when new chemicals added).

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section C: Hazardous Agents							
3-C-2	A	B	C-M	C	All explosive and combustible materials and supplies are stored and handled in a safe manner with appropriate ventilation according to state/provincial, local or national laws and regulations.		Verify the facility safely handles explosive and combustible materials according to: - Applicable fire and safety codes and worker safety regulations - Safety Data Sheets (SDS) or the manufacturer's instructions for use (IFU) - Government and regulatory requirements at the local, regional, or national level governing hazardous materials management and fire safety. Evaluating Compliance: Review policies for alignment with applicable fire and safety standards SDS or IFU Interview staff regarding procedures for handling explosive and combustible materials Inspect areas where such items are stored and handled to ensure: - Ventilation is adequate to code, or an extraction device is used in accordance with SDS or IFU - Combustible materials are stored at a minimum safe distance from ignition sources - Medical gases are secured.
3-C-4	A	B	C-M	C	Compressed gas cylinders are stored and handled in a safe manner according to local, state/provincial, or national laws and regulations.		Verify the facility safely stores and handles compressed gas cylinders according to: - Fire and worker safety standards - Government regulations (state/provincial/local/national) - Industry standards. Evaluating Compliance: Review policies for alignment with fire and worker safety standards, regulations, and protocols for storage and ventilation Inspect areas where gas cylinders are stored and handled to ensure: - Visible signage (e.g., hazards, no smoking) - Proper material segregation (e.g., by gas, empty versus full) - Cylinders are stored upright and secured - Ventilation is adequate - Stored at a minimum safe distance from ignition sources - Applicable spatial requirements are met.AC124
3-C-5	A	B	C-M	C	Hazardous chemicals are labeled as hazardous. Any hazardous material removed from the manufacturer's container and placed in a secondary container must be properly labeled.		Verify the facility ensures proper labeling per: - NFPA 704 standards - OSHA Hazard Communication Standard 1910.1200 (as applicable) - International fire and worker safety standards

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							This includes decanting hand soap or hand sanitizer from one container to another. Evaluating Compliance: Review the safety manual for: Hazard Communication Plan (updated annually) Hazardous chemical inventory (updated annually) Procedure for labeling hazardous chemicals that have been placed in a secondary container Interview staff regarding the procedure for labeling a secondary container, and locating SDS for a randomly chosen chemical Confirm secondary containers have appropriate labeling.
Sub-section D: Medical Hazardous Waste							
3-D-1	A	B	C-M	C	All medical hazardous wastes are disposed of in sealed, labeled containers and stored in compliance with federal/national, state, provincial, and local regulations and/or OSHA (Occupational Safety and Health Administration) acceptable containers and separated from general refuse for special collection and handling.		Verify the facility manages medical waste per federal/state or international regulations through: Proper containment (leak-proof biohazard bags/sharps containers) Secure transport/storage protocols Implementing a medical waste plan that addresses: Regular disposal to prevent accumulation Ventilated, pest-proof storage. Evaluating Compliance: Review policies to confirm the waste management plan includes: Containment standards (double-bagging if contaminated) Storage/transport requirements Interview staff regarding waste handling procedures Inspect waste disposal containers, procedures, and storage areas for Proper bag/container use (no overfilling) Labeled, puncture-resistant sharps containers Ventilated storage areas.
3-D-4	A	B	C-M	C	Used disposable sharp items are placed in secure puncture-resistant containers that are located as close to the use area as is practical.		Verify that the facility maintains safe sharps handling practices to prevent injuries and bloodborne pathogen exposure, in compliance with applicable occupational health, infection prevention, and product safety regulations — including U.S. standards (NIOSH, OSHA, FDA) or equivalent international or national standards (e.g., WHO, ISO, EU Directive 2010/32/EU). Requirements for sharps container design, functionality, and maintenance include: Puncture-resistant, leak-proof, and FDA-cleared Secure closures to minimize exposure Proper labeling (biohazard/warning symbols)

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Mounted securely or on wheeled bases (if floor-standing) Positioned near point of use and within horizontal reach (52–56 inches height recommended) Away from obstructed areas (e.g., under sinks) Replaced at $\frac{3}{4}$ capacity If reusable, containers must be FDA-approved, marked for reuse, and effectively disinfected. Evaluating Compliance: Review policies for alignment with OSHA 1910.1030 (Bloodborne Pathogens) and FDA standards or equivalent local/international regulation. Review documents to ensure any reusable containers meet FDA/DOT, or equivalent local/international regulation, reuse criteria Interview staff regarding one-handed sharps disposal and sharps container emptying practices Observe sharps containers in use to confirm: Fill level $\leq \frac{3}{4}$ capacity without protruding sharps Proper mounting or stability Compliance with placement/accessibility guidelines.
Sub-section E: Fire Safety							
3-E-1	A	B	C-M	C	The facility is equipped with functioning heat sensors and/or smoke detectors that are tested annually.		Verify the facility maintains a fully operational fire detection system (heat/smoke alarms) to ensure safety compliance. Evaluating Compliance: Review policies for Fire Safety (including maintenance protocols) Review documents for inspection records of detection systems Interview staff regarding alarm activation procedures and emergency response protocols Observe for proper placement of heat/smoke detectors and alarm system functionality.
3-E-2	A	B	C-M	C	The number of fire extinguishers available and their location must conform to local fire codes. Minimally, a fire extinguisher is located within 75 feet of any location in the facility. Fire extinguishers are visually inspected monthly, maintenance inspections are done annually and conform to local fire codes.		Verify the facility's fire extinguishers are: Sufficient in number (per square footage/local codes) Properly maintained per OSHA 29 CFR 1910.157 and NFPA 10 standards, or equivalent local/international regulation. Readily accessible (≤ 75 feet from any point) Key Requirements: Monthly visual inspection by staff: Observe for physical damage (dents/corrosion) Pressure gauge in green range

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Pull-pin/seal integrity Annual inspection by certified fire protection company: Full examination and tag verification Periodic (5–12 years*) internal maintenance by certified fire protection company Hydrostatic testing and component checks *Frequency varies by extinguisher type (e.g., 5 years for CO₂, 12 years for dry chemical). Evaluating Compliance: Review policies for alignment with OSHA and NFPA, or equivalent local/international regulation. Review documents confirming: Monthly inspection logs (last 12 months) Annual maintenance tags (current year) Internal maintenance records (per schedule) Inspect the facility to confirm extinguishers: Placed ≤ 75 feet apart and access not obstructed Have no physical damage Pressure gauges in "green" range.
Sub-section F: Exits							
3-F-3	A	B	C-M	C	There are sufficient emergency lights for exit routes and patient care areas in case of power failure.		Verify the facility provides emergency lighting for critical areas (patient care areas and exits). Evaluating Compliance: Review policies for power failure procedures that address: Emergency lighting duration Backup power sources Interview staff for knowledge of backup systems and emergency protocols Confirm emergency lighting in patient care zones and exit routes.
3-F-4	A	B	C-M	C	Hallways, stairways and elevators are sufficiently wide to allow emergency evacuation of a patient by emergency personnel and their equipment.		Verify the facility maintains unobstructed egress paths (hallways/stairways/elevators), including: Compliance with NFPA 101 Life Safety Code. or equivalent local/international regulation Compliance with local/state fire codes Ensuring minimum width requirements are met Keeping clutter out of evacuation routes. Evaluating Compliance: Review policies for alignment with NFPA/local regulations, or

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							equivalent local/international regulation, and emergency evacuation procedures Interview staff regarding emergency evacuation procedures Inspect the facility to confirm: - Corridor widths (≥ 44" for new healthcare) - Stairwell clearance - Non-obstructed pathways in evacuation routes.
Sub-section G: Personnel Safety							
3-G-1	A	B	C-M	C	If an ethylene oxide gas sterilizer or automated endoscope reprocessor (AER) is used, appropriate personnel are badge-tested to ensure that there is no significant ethylene oxide or glutaraldehyde exposure.		Verify the facility takes steps to protect staff from harmful exposure to Ethylene Oxide and Glutaraldehyde Exposure Information: - Ethylene Oxide (EtO) – OSHA-regulated carcinogen (29 CFR 1910.1047) - Glutaraldehyde – NIOSH REL 0.2 ppm (ACGIH TLV 0.05 ppm ceiling) Note: International facilities should abide by equivalent national safety organization recommendations. Evaluating Compliance: Review policies for procedures for EtO: - Confirm adherence to 29 CFR 1910.1047 or equivalent international regulation - Exposure monitoring (breathing zone samples) - Employee notification (≤ 15 days) - Exposure reduction Review policies for procedures for Glutaraldehyde: - Confirm adherence to NIOSH REL (0.2 ppm) and ACGIH TLV (0.05 ppm ceiling) or equivalent international requirement - Exposure reduction Review documents for monitoring results Interview staff regarding training and safeguards Observe for use of personal monitors in the workroom Review personnel records for evidence of staff training on safety procedures.
3-G-2				C	Personnel are properly trained in the control procedures and work practices that have been demonstrated to reduce occupational exposures to anesthetic gases.		Verify the facility implements four-tier controls and staff training to minimize anesthetic gas exposure, including: - Engineering (e.g., scavenging systems) - Work Practices (e.g., leak checks) - Administrative (e.g., rotation schedules)

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							PPE use when necessary (e.g., respirators). Evaluating Compliance: Interview staff regarding leak detection protocols and cases for PPE use Review training materials for inclusion of four-tier controls Inspect anesthesia workstations for scavenger systems Review personnel records for evidence of training (initial, annual).
3-G-3	A	B	C-M	C	There is a written policy for what is considered to be personal protective equipment for specific tasks in the facility (e.g., instrument cleaning, disposal of biological waste, surgery, radiology protection, exposure reduction, etc.).		Verify the facility maintains policies aligned with OSHA standards and implements task-specific PPE requirements. Evaluating Compliance: Review policies for PPE protocols addressing: High-risk tasks (e.g., anesthesia handling, chemical exposure) Minimum PPE standards (gloves, masks, eyewear, etc.) Interview staff regarding task-specific PPE use Observe adherence to PPE use and hazardous material handling during procedures and cleaning Review personnel records for evidence of training (initial, annual).
Sub-section H: Laboratory, Radiology Services, and Laser Safety							
3-H-2	A	B	C-M	C	If laboratory services are provided, these laboratory services must be provided in accordance with the Clinical Laboratory Improvement Act (CLIA) requirements at 42 CFR 493 operating under a current CLIA certificate appropriate to the level of services performed.		Verify the facility ensures laboratory services are performed safely and accurately in accordance with CLIA requirements or equivalent international/national laboratory quality standards. Evaluating Compliance: Review policies for directive to perform quality control testing per the manufacturer's instructions for use (IFU) Review CLIA or equivalent internationally recognized certificate for evidence that the: Type matches services provided (waived, provider-performed microscopy, moderate complexity) Laboratory Director credentials are current Review quality control logs and patient test documentation Interview staff regarding control procedures and equipment calibration (per IFU) Review personnel files for competency in laboratory tests provided.
3-H-3	A	B	C-M	C	If x-ray equipment is used, safety measures are taken to protect patients and staff from injury. Warnings and		Verify the facility minimizes risks from radiation exposure through the following: Proper PPE usage (lead aprons, thyroid shields)

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
					signage exist to warn those whose health may be affected by x-rays.		Using mobile shields/curtains Posting clear warning signage Following ALARA principles (As Low As Reasonably Achievable). Evaluating Compliance: Review policies for protocols for pregnant patients/staff and radiation exposure Review documents for reports determining staff radiation exposure Observe care to determine PPE use and shielding during imaging procedures Inspect PPE integrity and apron storage procedures (flat or on racks) Confirm warning signs in imaging areas.
3-H-4	A	B	C-M	C	If X-ray is used, staff maintain dosimetry badges and records, if applicable, for at least three (3) years.		Verify the facility implements personal radiation dosage monitoring, including: Personal dosimetry badges (not area monitoring) Badge usage is worn daily over lead aprons (at collar/chest level) Not sharing badges between staff Reviewing exposure reports quarterly (or per regulatory requirements). Evaluating Compliance: Review policies for directives for: Individual badge assignment Proper positioning of monitoring device (over lead) Quarterly reporting Review documents for evidence of exposure reports for the past three (3) years Observe procedures with radiation exposure for evidence of badge placement Review personnel records for quarterly exposure reports and employee acknowledgement.
3-H-8	A	B	C-M	C	If a laser is used, all manufacturer recommended safety precautions are actively in place prior to any usage. All safety measures are taken to protect patients and staff from injury, including appropriate eyewear, covered mirrors, covered windows, signage on the door, etc. in accordance with state/provincial laws and regulations.		Verify that the facility implements all manufacturer-recommended safety precautions when using lasers to protect patients, staff, and visitors from injury, in accordance with applicable state/federal or international (provincial/national) regulations. Evaluating Compliance: Review policies for: Compliance with ANSI Z136.3, or equivalent (e.g. ISO, IEC) standards Laser inventory with classification Inclusion of pre-procedure safety checks

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Designation of a Laser Safety Officer (LSO) who is qualified for all laser types Implementing procedure-specific safety protocols Review governing body appointment of LSO Interview staff regarding laser safety protocols Request IFU for a random piece of laser equipment, confirm staff access, and use is compliant with IFU Observe laser procedures for “Laser in Use” signage and PPE use (when possible) Review personnel records for evidence of initial/annual training.

SECTION 4: EQUIPMENT

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section A: Facility Equipment							
4-A-1	A	B	C-M	C	If a central source of piped oxygen is used, the system must meet all applicable local, state/provincial, and country safety codes.		Verify that medical gases are supplied, stored, and used in compliance with applicable national regulations and recognized standards, such as FDA/USP for the U.S., EMA/Ph. Eur. for Europe, or ISO standards internationally. Suppliers should be licensed or certified by the appropriate national or regional authority. Key Requirements: - Certified verifier for central systems - Category-appropriate compliance - Documented corrective actions for identified issues. <u>Evaluating Compliance:</u> Review documents: - Certified verifier reports from qualified technician - Corrective action logs - Confirm testing frequency matches IFU Inspect systems to spot-check actual vs prescribed oxygen delivery.
4-A-2	A	B	C-M	C	Medical equipment and supplies are available in the facility in appropriate sizes and quantities based on the patient population served.		Verify the facility maintains age-appropriate equipment/supplies for all patient populations served to ensure an adequate inventory to support safe patient care <u>Evaluating Compliance:</u> Review policies for pediatric population definition (if relevant) Review documents for evidence of inventory checks of supplies and equipment maintenance Interview staff regarding process for checking inventory of supplies/equipment for use Inspect facility inventory to confirm adequate inventory and presence of medical equipment for relevant patient populations (i.e. pediatrics) and range of size-appropriate supplies (e.g., airway devices, BP cuffs).
Sub-section B: Operating Room Equipment							
4-B-2	A	B	C-M	C	There is a properly functioning operating room table or chair.		Verify all OR tables and chairs function properly for safe patient positioning and are adequate to support intended procedures.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							<u>Evaluating Compliance:</u> Review documents preventive maintenance records Interview staff regarding routine maintenance, malfunction reporting, and weight capacity awareness Observe tables and chairs to ensure: Function of height/tilt mechanisms, locking features, and emergency release Integrity of the padding.
4-B-3		B	C-M	C	The operating room is provided with functioning lighting in the ceiling based on the types of cases performed. Illumination for patients, machines, and monitoring equipment, and access to battery-powered illuminating systems are present.		Verify the facility maintains adequate primary lighting to critical areas of the operating room (e.g., surgical field, monitoring equipment, machine displays) Emergency backup systems must be present, using either: Battery-powered units (with immediate activation) Generator backup (activates within 10 seconds). <u>Evaluating Compliance:</u> Review documents: Battery unit inspection logs (monthly) Generator maintenance records Interview staff regarding emergency lighting protocols Inspect OR lighting intensity Confirm battery backup activation (power interruption simulation) or generator transition (≤10 second delay).
4-B-5		B	C-M	C	Sufficient electrical outlets are available, labeled and grounded to suit the location (e.g., wet locations) and connected to emergency power supplies where appropriate.		Verify the electrical systems in the operating room: Provide adequate outlets for procedural equipment Meet wet location requirements (unless risk assessment exempts) <u>Evaluating Compliance:</u> Interview staff regarding emergency power protocols Inspect operating rooms to verify: GFCI in wet locations Outlets with emergency power supply are labeled Proper grounding Clear labeling/grounding Emergency power connections for critical devices Confirm that each operating/procedure room has at least enough outlets to support all patient-care and procedural equipment without using extension cords. However, depending on the program type, essential electrical system, and if a Life Safety Code is required, as

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							many as 36 receptacles may be required in each operating room Confirm emergency outlets function by simulating a power failure.
4-B-6			C-M	C	Sequential compression devices (SCD) are employed for operations lasting one (1) hour or longer, except for operations carried out solely under local or topical anesthesia.		Verify the facility implements venous thromboembolism (VTE) prophylaxis for procedures lasting greater than 60 minutes. <u>Evaluating Compliance:</u> Review policies for: SCD use protocols Exemptions (e.g., pediatrics, lower extremity procedures) Interview staff regarding indications/contraindications of SCD use and application protocols Observe care provided in the facility for evidence of intraoperative SCD use Confirm SCD equipment is functional and single-use supplies are adequate Review clinical records (5 recent cases lasting >60 minutes) for documentation of SCD application (or contraindication for use).
4-B-7		B	C-M	C	A source of cautery is present in the operating room. When unipolar electrocautery is used, a single-use/ disposable or reusable grounding pad is used.		Verify the facility safely operates electrosurgical equipment per manufacturer's instructions for use (IFU) <u>Evaluating Compliance:</u> Review manufacturer's IFU and reprocessing logs for reusable grounding pad devices Interview staff regarding device-specific protocols and reprocessing steps for reusable devices Observe care provided in the facility for evidence of: Intraoperative use of grounding pads Correct pad placement (unipolar systems) High-temperature cautery pens (no grounding pad) Inspect supplies to confirm single-use devices are not reprocessed Review clinical records for documentation of grounding pad usage (when applicable).
4-B-8			C-M	C	"Forced air warmers," blanket warmers, or other interventions are used to maintain the patient's temperature when the procedure lasts more than 60 minutes. The patient's temperature is monitored periodically to ensure normothermia.		Verify the facility mitigates risk of perioperative hypothermia through active warming protocols and documents compliance during all phases of care. Critical warming recommendations by phases include: Pre-Operative Documents baseline temperature at admission Active warming preferred, may use warm blankets for cases under 60 minutes

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Intra-Operative - Begins active warming before induction - Maintain IV fluids/blood at 37°C and warm irrigation fluids to 38-40°C - Document temperature regularly (at least hourly) - Use core temperature monitoring when possible Post-Operative - Monitor temperature every 15 minutes until normothermic ($\geq 36^{\circ}\text{C}$) - Do not discharge if temperature $<36^{\circ}\text{C}$. <u>Evaluating Compliance:</u> Review policies for: - Evidence of temperature thresholds - Hypothermia prevention protocols - Frequency of temperature monitoring Interview staff regarding hypothermia prevention protocols and active warming device safety Observe care provided in the facility for evidence of perioperative patient warming Inspect active warming equipment for integrity and verify use is according to manufacturer's IFU Confirm safe temperature ranges for fluids and blankets stored in warmers Review clinical records (5 recent cases) for temperature documentation in all phases of care.
Sub-section C: Anesthesia Equipment							
4-C-1		B	C-M	C	The operating room is equipped with an EKG monitor with pulse read-out.		Verify the facility can perform continuous circulatory monitoring during the delivery of all anesthetics <u>Evaluating Compliance:</u> Review documents for (at least) annual inspection of EKG equipment Confirm the presence of a functional EKG monitor in each operating room/procedure area Observe settings to ensure alarms are set and audible Inspect the cart to ensure EKG electrodes are not expired.
4-C-2		B	C-M	C	The operating room is equipped with a pulse oximeter.		Verify the facility can perform continuous pulse oximetry monitoring to detect hypoxemia during Class B, C-M (international only), and C anesthesia cases <u>Evaluating Compliance:</u>

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Review documents for (at least) annual inspection of all pulse oximeters Confirm the presence of a functional pulse oximeter in each operating room/procedure area Confirm sensor selection is available (adult/pediatric) Observe settings to ensure alarms are set and audible.
4-C-3		B	C-M	C	The operating room is equipped with blood pressure monitoring equipment, including cuff sizes as appropriate for the patient population treated in the facility.		Verify the facility can perform continuous blood pressure monitoring Equipment Standards: - Operational BP monitor present - A variety of BP cuff sizes are available for all patient populations served - Annual performance verification per manufacturer specifications - Alarm thresholds set appropriately, if applicable. <u>Evaluating Compliance:</u> Review documents for (at least) annual inspection of all blood pressure monitors Confirm the presence of a functional blood pressure monitor in each operating room/procedure area Inspect the cart to ensure an adequate supply and a variety of cuff sizes are available (adult/pediatric) Observe settings to ensure alarms are set and audible, if applicable.
4-C-4		B	C-M	C	The operating room is equipped with oral airways including sizes specific for each size of patient population treated in the facility.		Verify the facility maintains a comprehensive range of oral airway devices for all patient populations served Equipment Standards: - Devices should be color-coded or clearly labeled for rapid size identification - Packaging must remain intact until time of use. <u>Evaluating Compliance:</u> Inspect cart to ensure an adequate supply and variety of oral airway sizes are available in each operating room/procedure area Confirm pediatric sizes are stocked (if applicable).
4-C-5		B	C-M	C	The operating room is equipped with nasopharyngeal airways including sizes specific for each size of patient population treated in the facility.		Verify the facility maintains a comprehensive range of nasopharyngeal airway devices for all patient populations served Equipment Standards: Devices should be color-coded or clearly labeled for rapid size

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							identification Packaging must remain intact until time of use. <u>Evaluating Compliance:</u> Inspect cart to ensure an adequate supply and variety of nasopharyngeal airway sizes are available in each operating room/procedure area Confirm pediatric sizes are stocked (if applicable).
4-C-6		B	C-M	C	The operating room is equipped with a functional and clean laryngoscope. Laryngoscope is cleaned as appropriate, HLD or sterilized. Permitted in Class B for emergency use only.		Verify the facility maintains functional laryngoscopes for all patient populations served Equipment Standards: Single-use laryngoscopes remain in packaging and are function-tested immediately before use Reusable laryngoscopes: Cleaned/sterilized per manufacturer's instructions for use (IFU) Sterilized blades remain in sterile packaging until function-testing immediately before use Disinfected handles are stored in a manner to protect against cross-contamination Laryngoscopes are function-tested immediately before use. <u>Evaluating Compliance:</u> Review reprocessing logs to ensure they are comprehensive Interview staff regarding cleaning procedures and inspection of items for package integrity Inspect cart for adequate supply, package integrity, and storage conditions in each operating room/procedure Verify laryngoscopes are identified as clean
4-C-7		B	C-M	C	The operating room is equipped with a comprehensive assortment of endotracheal tubes, stylets, and laryngeal mask airways including sizes and types for the patients being treated in the facility. Permitted in Class B for emergency use only.		Verify the facility maintains an adequate inventory and a complete range of advanced airway devices for all patient populations served. Advanced airway devices must be immediately available in all anesthetizing locations and have comprehensive records for any devices approved for re-sterilization (or for limited re-sterilization) consistent with the manufacturer's instructions for use (IFU) <u>Evaluating Compliance:</u> Review reprocessing logs to ensure they are comprehensive Interview staff regarding process for checking inventory, cleaning procedures, and difficult airway protocols Inspect cart for adequate supply and sizes, package integrity, and

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							storage conditions in each operating room/procedure area Confirm availability of pediatric sizes (if applicable).
4-C-9		B	C-M	C	The operating room is equipped with a positive pressure ventilation device (e.g. Ambu® bag, bag valve mask), including sizes of masks to cover the range needed for the patient population treated in the facility. If self-inflating bags are used, they must be capable of delivering positive-pressure ventilation with at least 90% oxygenation concentration.		Verify the facility maintains and adequate supply of functional positive-pressure ventilation devices with capabilities to ensure adequate oxygenation ($\geq 90\%$ FiO₂ when needed) for all patient populations served. Evaluating Compliance: Review daily checklists to ensure these devices are available Interview staff regarding inspection of items for package integrity and emergency ventilation protocols Have staff demonstrate adequate tidal volume delivery of $\geq 90\%$ FiO₂ with flowmeter at 15 LPM Inspect device(s) for intact tubing/valves, device integrity, manufacturer's expiration date when applicable, and storage conditions.
4-C-10		B	C-M	C	The operating room is equipped with a source of oxygen and with appropriate delivery devices (e.g. nasal cannula, face mask) to provide adequate oxygen for the patient population treated and procedures performed in the facility.		Verify the facility maintains immediate oxygen sources (piped access or full E-cylinders with >500 psi) and appropriate delivery devices in operating room for all patient populations served Equipment Standards: Availability of nasal cannulas, non-rebreather masks, and (if needed) Venturi masks Single-use Packaging must remain intact until time of use. Evaluating Compliance: Review medical gas logs Interview staff regarding daily checklists and inspection of items for package integrity Inspect oxygen sources (primary, backup) to confirm flowmeter function, adequate inventory of delivery devices, package integrity, and storage conditions in each operating room/procedure area Confirm pediatric supplies (if applicable).
4-C-11		B	C-M	C	The operating room is equipped with a source of adequate and reliable suction and suction equipment.		Verify the facility maintains immediate, reliable access to suction (wall/portable) and adequate supplies in the operating room(s) for all patient populations served. Evaluating Compliance: Review preventive maintenance records Interview staff regarding daily checklists and emergency backup if the

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							access is piped Inspect suction access for functionality/pressure gauge, adequate supply of tubing/catheter sets (Yankauer), package integrity, and storage conditions in each operating room/procedure area.
4-C-12		B	C-M	C	The operating room is equipped with a reliable source of oxygen, adequate for the length of the procedures performed in the facility (backup must consist of at least one full E cylinder). Backup oxygen source must have a regulator and be ready to use. If oxygen cylinders are used as backup, they must be full.		Verify the facility maintains an adequate supply of oxygen (piped access/full E-cylinder with regulator in place) in the operating room(s). Evaluating Compliance: Review medical gas logs Interview staff regarding daily checklists, inspection of pressure gauges, and emergency protocols for piped access failure Inspect oxygen sources (primary, backup) to confirm availability in each operating room/procedure area Confirm the E-cylinder has a regulator on and is showing the pressure gauge as full.
4-C-13				C	If inhalation general anesthesia is used, the operating room is equipped with an inspired gas oxygen monitor on the anesthesia machine with an audible alarm to indicate a low oxygen concentration.		Verify the anesthesia machine measures inspired oxygen concentration continuously and has audible alarms for hypoxic gas mixtures (< 21% O ₂). Evaluating Compliance: Interview anesthesia staff regarding use of oxygen analyzer Request a demonstration of device functionality and response to hypoxia Confirm alarm threshold settings and audible/visual low-O ₂ alarm.
4-C-14		B	C-M	C	The operating room is equipped with an end tidal carbon dioxide monitor with an audible alarm to indicate values outside the normal range which is used on all moderate sedation, deep sedation, and general anesthesia cases.		Verify the facility monitors ventilation continuously for all patients under moderate/deep sedation and general anesthesia using capnography (ETCO ₂) in the operating room(s). Evaluating Compliance: Interview staff regarding use of ETCO ₂ monitoring during procedures Confirm an ETCO ₂ monitor is present in each operating room/procedure area with: Waveform display Audible alarms (apnea/hypoventilation) Alarm responsiveness Confirm adequate supply of single-use tubing used in monitoring Review clinical records (recent cases undergoing moderate/deep sedation or general anesthesia) for documentation of ETCO ₂ monitoring.

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4-C-15				C	When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting the disconnection of any of the breathing system's components. The device must give an audible signal when its alarm threshold is exceeded.		Verify the facility maintains functional mechanical ventilators that monitor circuit integrity (disconnection detection) and alert clinicians via audible alarms for critical events. <u>Evaluating Compliance:</u> Interview staff regarding: Daily anesthesia equipment checks Apnea alarm responsiveness Request a demonstration of: Simulated circuit disconnection to ensure an alarm within 15 seconds Alarm silencing/reset procedure Confirm device alarm functionality for disconnect detection and audible and visual high/low pressure alerts in each operating room/procedure area.
4-C-16	A	B	C-M	C	If nitrous oxide alone is used, then a safe delivery system is used. A safe delivery system meets these criteria: 1) Alarms 2) Gas scavenging 3) Color coding of tanks, knobs, and hoses 4) Diameter index safety system for non-interchangeable connection of gases - pin index safety system 5) Oxygen fail-safe system and oxygen flush capacity 6) Quick connection for positive-pressure oxygen delivery 7) Emergency air inlet 8) Reservoir bag 9) Storage in a secured area		Verify the facility maintains safe nitrous oxide delivery systems, including: Maintaining a minimum of 25% oxygen concentration at all times Incorporating fail-safes to prevent hypoxic gas delivery Alignment with Standard 3-A-1 and Nitrous Oxide Addendum requirements. <u>Evaluating Compliance:</u> Review policies for: Procedures for safe use of nitrous oxide delivery systems Monitoring records for nitrous oxide Review preventive maintenance logs and safety inspection records Interview staff on knowledge of safety protocols and response to alarms for hypoxic mixtures Inspect system in each operating room/procedure area the system is used for: Oxygen fail-safe valve (functional test) Proportioning system (25% O₂ minimum) Backup O₂ flush mechanism Confirm visual alerts/audible alarms for Hypoxic mixture (<25% O₂).
4-C-17				C	An anesthesia machine with a purge system to extract exhaled gaseous air to out-of-doors or to a neutralizing system is present. If inhalation anesthesia is used, a carbon dioxide-neutralizing system is required when using an anesthesia machine.		Verify the facility prevents unintended exposure to harmful gases by using: Functional purge systems CO₂-neutralizing systems (if applicable) Effective waste gas scavenging. <u>Evaluating Compliance:</u>

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					An adequate and reliable waste anesthetic scavenging system exists if inhalation anesthetics are used.		Interview staff regarding daily safety checks, leak detection, and absorbent material replacement Inspect equipment in each operating room/procedure area for: Purge system: Proper exhaust routing No leaks (soap bubble test) Scavenging system: Active suction (≥ 25 LPM flow) Proper interface with machine CO ₂ management (if used): Absorbent canister color change indicator Last change date documented.
4-C-18				C	An anesthesia machine is required if volatile agents are available in the facility. If total intravenous anesthesia (TIVA), spinal, or epidural anesthesia is used exclusively, and no volatile inhalation agents are available, an anesthesia machine is not required.		Verify the facility meets all facility Class C standards if volatile anesthesia agents are administered. <u>Evaluating Compliance:</u> Interview staff to determine: Availability or use of volatile agents within the facility (e.g., sevoflurane, isoflurane) Anesthesia machine maintenance protocols Confirm use of anesthesia machine in each operating room/procedure area when volatile agents (e.g., sevoflurane, isoflurane) are administered.
Sub-section D: Post-Anesthesia Care Unit (PACU) Equipment							
4-D-1		B	C-M	C	The PACU is equipped and readily accessible to handle emergencies		Verify the PACU is fully equipped to handle patient emergencies in the dedicated area for patient recovery after surgery or procedures. <u>Evaluating Compliance:</u> Review documents for evidence of: Checklists confirming readiness of emergency equipment and adequate supplies Preventive maintenance on emergency equipment Interview staff regarding emergency responses often seen in the post-anesthesia phase (e.g., airway, cardiac) Confirm access to an emergency cart (airway devices, supplies), defibrillator, oxygen source, and suction.
4-D-2		B	C-M	C	A separate pulse oximeter is available for each patient in the PACU.		Verify the facility provides for continuous pulse oximetry for all patients in PACU, including: Maintaining adequate equipment for 1:1 patient monitoring Documenting compliance with oxygenation protocols.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							<u>Evaluating Compliance:</u> Review policies for protocols addressing equipment cleaning and hypoxia response Interview staff regarding alarm threshold and artifact resolution Request demonstration of alarm thresholds settings (typically SpO₂ <90%) Observe patient care in the PACU for evidence of: Audible pulses and alarms Adequate pulse oximetry equipment for patient population Confirm inventory of functional probes (adult/pediatric sizes) Review clinical records (≥ 5 recent cases) for evidence of pulse oximetry monitoring in the post-anesthesia phase.
Sub-section E: Maintenance of Equipment							
4-E-1	A	B	C-M	C	The facility has a preventive maintenance program to ensure that all essential mechanical, electric and patient-care equipment is maintained in safe operating condition and is replaced no less frequently than according to a schedule. A qualified technician annually inspects all equipment and reports in writing that the equipment is safe and operating according to the manufacturer's specifications. Stickers may be placed on individual equipment; however, written records must be maintained. All equipment is on a maintenance schedule, and records are kept for a minimum of at least three (3) years.		Verify the facility maintains all equipment per manufacturer specifications in the instructions for use (IFU) <u>Evaluating Compliance:</u> Review documents for: Inventory log with maintenance schedules Annual Bio-medical inspection reports by qualified technicians Critical equipment calibration (e.g., anesthesia machine, lasers) reports 3-year maintenance of logs and records Review ≥ 5 pieces of equipment for functionality and inspection dates Interview staff regarding protocols for reporting equipment malfunction and out-of-service storage Inspect quarantine area for faulty equipment Inspect equipment for dated inspection stickers or documented inspection.
4-E-5	A	B	C-M	C	The manufacturer's specifications and requirements for all equipment are kept in an organized file and followed for each piece of equipment.		Verify the facility retains manufacturer instructions for use (IFU) for all equipment and implements the specified maintenance and testing procedures. <u>Evaluating Compliance:</u> Interview staff regarding location and access to IFUs, process for incorporating new equipment Inspect ≥ 5 randomly selected pieces of equipment: Confirm inclusion in inventory log (by matching model numbers) Cross-check maintenance schedules and calibrations with the IFU.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
4-E-6		B	C-M	C	The facility's emergency backup power equipment is tested monthly and according to the manufacturer's recommendations to ensure proper function in accordance with federal/national, state, provincial, and local requirements, if applicable. The test results are filed and kept for a minimum of three (3) years.		Verify the facility maintains access to reliable emergency power by: Performing monthly generator testing (30+ minutes under load) that verifies: Stable oil/water pressures (or shortened test if needed) Minimum exhaust temperature OR ≥30% nameplate kW load Performing annual load bank testing (2 hours) for failed units: Progressive loading (25% → 50% → 75% kW) Documenting compliance by qualified technicians (3-year retention). Evaluating Compliance: Review policies for alignment with NFPA 110 (8.4.2/8.2.4.3) or equivalent international fire-related hazard codes, and technician qualification standards Review testing logs for runtime duration, load levels achieved, technician signatures Review annual load bank tests (if triggered) Interview staff regarding abbreviated test protocols and load bank procedures.
4-E-10	A	B	C-M	C	The facility regularly conducts appropriate testing in accordance with the manufacturer's specifications for all equipment. Records of that testing are maintained within the facility for at least three (3) years.		Verify the facility implements the specified maintenance and testing procedures as recommended by the manufacturer's instructions for use (IFU). Evaluating Compliance: Review documents for: Inventory log and maintenance schedules per IFU Equipment test records from past 3 years Maintenance logs Interview staff regarding testing procedures/frequency and process for incorporating new equipment Inspect ≥ 5 randomly selected pieces of equipment: Confirm inclusion in inventory log (by matching model numbers) Cross-check testing schedules and calibrations with the IFU.
4-E-11	A	B	C-M	C	All equipment not requiring a qualified technician inspection is on a preventative maintenance schedule with appropriate records kept for a minimum of 3 years (examples include manual wheelchair, manual stretcher, etc.).		Verify the facility performs periodic inspections on non-technical equipment (e.g., manual wheelchairs, stretchers). Evaluating Compliance: Review policies for preventative maintenance of non-technical equipment, to include: Maintenance schedules Staff responsibilities Inspection/service report retention (3-year minimum)

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Cleaning schedule Review documents for evidence of inspection reports and service records (current, archived) Interview staff regarding process for reporting equipment issues and incorporating new equipment.

SECTION 5: IN CASE OF EMERGENCY

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section A: Emergency Equipment							
5-A-1	A	B	C-M	C	Emergency cart is immediately available with a defibrillator or automated external defibrillator (AED), necessary drugs, and other CPR equipment (e.g. suction, pediatric defib pads) necessary for the patient population being served.		Verify the facility's emergency equipment is immediately available whenever patients are present. For procedural/surgical facilities, contract anesthesia providers must remain onsite with their emergency supplies until all patients are discharged. RHCs should perform risk assessments to determine needed equipment beyond the required automated external defibrillator. <u>Evaluating Compliance:</u> Review documents for evidence of: Emergency equipment checklists Anesthesia provider agreements (when applicable) Emergency equipment risk assessment (RHCs) Interview staff regarding: Emergency equipment location and use protocols Anesthesia staffing and services provided (if applicable) Inspect the emergency cart to ensure it is fully stocked with functional equipment, in-date supplies, and in-date medications required for resuscitation Confirm RHCs have the equipment, supplies, and medications identified from the risk assessment.
5-A-3	A	B	C-M	C	The standard defibrillator, or an Automated External Defibrillator (AED), is checked at least weekly for operability in accordance with the manufacturer's instructions for use, and the test results are documented and kept for a minimum of three (3) years.		Verify the facility maintains a functional defibrillator/AED for emergency use. <u>Evaluating Compliance:</u> Review policies for directives that emergency equipment is checked/replaced according to the manufacturer's instructions for use (typically every 2-4 years for batteries, every 2 years for pads) Review documents for evidence of: Battery/defibrillator pads reviewed in emergency equipment checklists Weekly defibrillator checks (maintained for 3 years) Interview staff regarding defibrillator testing protocols and procedures for use Inspect defibrillator to confirm functionality and pad integrity Confirm no expired supplies are present.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
5-A-4		B	C-M	C	The facility medical staff, anesthesia professionals, other clinical staff, and the governing body of the facility coordinates, develops, and revises facility policies and procedures to specify the types of emergency equipment required for use in the facility's operating room.		Verify that the facility's medical staff and governing body have adopted written policies and procedures addressing the specific types of emergency equipment that must be available in the facility's operating room. The facility is expected to maintain a comprehensive, current, and appropriate set of emergency equipment, supplies, and medications that meet current standards of practice and are necessary to respond to patient emergencies. The facility must also conduct periodic assessments of these policies and procedures to ensure it can anticipate the emergency equipment, supplies, and medications needed to address likely emergencies, taking into consideration the types of patients it serves and the types of procedures performed. This requirement is increasingly important as more complex surgical procedures shift from the inpatient setting to the outpatient environment. Evaluating Compliance: Review policy on emergency equipment and supplies Interview staff to determine: They know where the emergency equipment is located How simultaneous emergencies are handled How are the emergency supplies and medications determined Verify designated emergency equipment is immediately available to the OR Verify there are sufficient clinical staff qualified to utilize the emergency equipment, medications, and supplies Verify emergency supplies and medications are current and not expired.
5-A-5	A	B	C-M	C	The emergency equipment must be immediately available for the use of emergency situations.		Verify that the facility has adequate supply of emergency equipment and supplies immediately available to the operating room(s) (OR). The equipment and supplies must be in working condition. The facility's policies must address whether the equipment and supplies must be present in each OR, or in what quantity and location(s) they will be available to all ORs as needed. The facility must ensure that qualified staff are available who are capable of using all emergency equipment as needed. Staff must be able to operate the emergency equipment in accordance with their scope of practice. There is no requirement for all clinical staff to be trained on every piece of emergency equipment; however, whenever a patient is in the operating room, there must be staff present who are qualified to use the necessary emergency equipment.

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							<u>Evaluating Compliance:</u> Determine whether the designated emergency equipment is immediately available to the OR(s) if needed. Interview staff to determine if they know where the emergency equipment is located.
5-A-6	A	B	C-M	C	The emergency equipment must be appropriate for the facility's patient population.		Verify that the facility incorporates emergency equipment, supplies, and medications that are appropriate for the potential emergencies associated with the procedures performed and the population served. The facility's policies must account for the characteristics of its patient population, including any prevalent risks or co-morbidities. The facility must also consider the types of procedures performed, the anesthesia used, and the specific risks or types of emergencies that may arise from those procedures. For example, a facility that routinely treats pediatric patients must ensure it maintains emergency equipment and supplies in sizes and configurations appropriate for pediatric use. <u>Evaluating Compliance:</u> Verify emergency equipment, supplies, and medications meet the emergency needs of the patients, taking into account the patient population and types of procedures performed and anesthesia used.
5-A-7	A	B	C-M	C	The emergency equipment must be maintained by appropriate personnel.		Verify that all mechanical and electrical emergency equipment is regularly inspected, tested, and maintained to ensure it is available and functional when needed. Emergency supplies and medications must be routinely monitored and replaced whenever they are used or reach their expiration date. The facility must utilize qualified personnel—or qualified contracted staff—to perform maintenance of emergency equipment. <u>Evaluating Compliance:</u> Verify that mechanical and electrical emergency equipment is regularly inspected, tested, and maintained Verify supplies and medications are current and not expired.
Sub-section B: Emergency Power							
5-B-1		B	C-M	C	The emergency power source is able to begin generating ample power to operate essential electrical equipment used		Verify the facility's emergency power systems are maintained, including:

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					in the operating suite within thirty (30) seconds of a power failure.		Automatically engaging within 30 seconds during power outages Testing is performed per the manufacturer specifications Records of testing/maintenance retained for at least three (3) years. Evaluating Compliance: Review policies for directives that: Testing frequency aligns with manufacturer requirements Testing personnel is designated Emergency power sources must engage within 30-seconds Contingency procedures for failures (e.g., not starting new cases when on emergency power) Review documents for emergency power testing (as required) and corrective action with any test failures Interview staff regarding testing protocols and emergency power procedures Confirm there are no unresolved test failures.
5-B-2	B	C-M	C		The operating room(s) and PACU have an emergency power source, (e.g. a generator or battery powered inverter), with capacity to operate critical equipment (e.g., ventilators, lighting, monitoring, anesthesia, and procedure equipment) for a minimum of 90 minutes. If two or more operating rooms are used simultaneously, an adequate emergency power source must be available for all operating rooms.		Verify the facility has an independent emergency power system (EPS) meeting NFPA 110 Sections 7.9.1 (for U.S> facilities) or equivalent national or international standards for emergency electrical systems. Evaluating Compliance: Review policies for: EPS testing alignment with NFPA or equivalent national or international standards for emergency electrical systems Testing frequency (monthly, annual, per manufacturer's specifications) Protocols activated during power loss Record retention (at least 3 years). Response for testing failures 90-minute lighting requirement EPS activation protocols (e.g., not starting new cases whilst on emergency power) Review documents for evidence of: Logs demonstrating regular system checks and successful 90-minute validations Reports of corrective actions with test failures Interview staff regarding knowledge of EPS activation protocols.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section C: Emergency Protocols							
5-C-1	A	B	C-M	C	There must be a written protocol for emergency evacuation of the facility. The protocol must include provisions for annual drills for the emergency evacuation of patients, staff, and guests; staff training upon hire and annually. Documentation of all drills must be retained in the facility for a minimum of three (3) years.		Verify the facility maintains comprehensive emergency preparedness, including: - Annual review/updates of emergency evacuation protocols - Facility holds an emergency evacuation drill annually (date/time, details, attendees, after-action report) - Staff training (initial, annually, after protocol changes) - Record retention of three (3) years Drill content should vary in terms of time, location, and scenario. Drills and training are separate components. Not all staff are expected to participate in the scheduled drill, as staff may not be scheduled to work that day. <u>Evaluating Compliance:</u> Review policies for: - Evacuation procedures - Roles/responsibilities - Evidence of annual review Review drill documentation for required components, frequency not >365 days, retention for three (3) years Interview staff regarding emergency procedures and individual responsibilities Review personnel records for evidence of training (initial, annually, updates) Deficiency citations for training gaps should be documented under standard 11-I-4.
5-C-2	A	B	C-M	C	A written protocol for security emergencies, such as an intruder in the facility, an unruly patient or visitor, or a threat to the staff or patients, must be documented and reviewed annually. The protocol must include provisions for annual drills for security emergencies, staff training upon hire and annually, drill documentation, and, retention of documentation for a minimum of three (3) years.		Verify the facility maintains comprehensive emergency preparedness, including: - Annual review of security emergency protocols addressing: - Intruders, unruly persons, bomb threats, and other threats to staff or patients - Annual drills (documenting date/time, scenario, attendees, and after-action report) - Staff training (at hire, annually, after protocol changes) - Record retention (3 years) Drill content should vary in terms of time, location, and scenario. Drills and training are separate components. Not all staff are expected to participate in the scheduled drill, as staff may not be scheduled to work that day.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							<u>Evaluating Compliance:</u> Review policies for: Security emergency procedures Roles/responsibilities Evidence of annual review Review documentation for required components, frequency not >365 days, retention for three (3) years Interview staff regarding security emergency procedures and individual responsibilities Review personnel records for evidence of training (initial, annual, updates) Deficiency citations for training gaps should be documented under standard 11-I-4.
5-C-3	A	B	C-M	C	There must be a written protocol for fires and fire drills. This protocol must include the provision for: fire drills; staff training upon hire and annually; drill documentation and retention of documentation for a minimum of three (3) years.		Verify the facility maintains comprehensive emergency preparedness, including: Annual review of fire response procedures Annual drills (documenting date/time, scenario, attendees, and after-action report) Staff training (at hire, annually, after protocol changes) Record retention of three (3) years Drill content should vary in terms of time, location, and scenario. Drills and training are separate components. Not all staff are expected to participate in the scheduled drill, as staff may not be scheduled to work that day. <u>Evaluating Compliance:</u> Review policies for: Fire response procedures Evacuation routes Roles/responsibilities Evidence of annual review Review documentation for required components, frequency not >365 days, retention for 3 years Interview staff regarding fire response procedures and individual responsibilities Review personnel records for evidence of training (initial, annual, updates) Deficiency citations for training gaps should be documented under standard 11-I-4.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
5-C-4	A	B	C-M	C	There must be a written protocol for returning patients to the operating room or transfer to the hospital in the event of patient emergencies.		Verify the facility maintains a comprehensive policy for unplanned returns to the OR, including: - Annual review of policy - Defining the notification chain (family, anesthesia, charge RN, emergency contacts) - Maintenance of NPO status - Consent acquisition process - Documentation standards - Staff training (initial, annual, with updates) - QUAD A reporting requirements (via PSDR portal). Evaluating Compliance: Review policies for inclusion of required elements, QUAD A reporting, and evidence of annual review Interview staff regarding notification procedures, maintaining NPO status, attaining consent, documentation requirements, and QUAD A reporting Review personnel records for evidence of training (initial, annual, with updates) Deficiency citations for training gaps should be documented under standard 11-I-4.
5-C-7	A	B	C-M	C	There must be a written protocol for a situation in which the surgeon/proceduralist, anesthesia professional, or other healthcare professional is impaired or becomes incapacitated.		Verify the facility maintains a comprehensive policy for addressing impaired/incapacitated healthcare professionals, including: - Annual review of policy - Clear steps for: - Identification of impairment/incapacitation - Immediate response actions - Reporting procedures - Patient safety measures - Staff training (initial, annual, with updates). Evaluating Compliance: Review policies for inclusion of required elements and evidence of annual review Interview staff regarding recognition of impairment, immediate response, and chain of command reporting Review personnel records for evidence of training (initial, annual, with updates).
5-C-11	A	B	C-M	C	There must be a written protocol for isolation procedures.		Verify the facility implements a comprehensive policy to minimize the risk of transmission of infections that aligns with recognized infection prevention and control guidelines, including:

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							Annual review of policy Inclusion of Standard Precautions Inclusion of Transmission-Based Precautions (for airborne, contact, droplet diseases) Surveillance for symptoms of active infection Triage, isolation of patient, and use of appropriate barriers (e.g., mask the patient, cover wound) Staff training (initial, annual, with updates). <u>Evaluating Compliance:</u> Review policies for inclusion of required elements and evidence of annual review Interview staff regarding knowledge of transmission-based precautions and environmental cleaning Observe patient care for compliance with Standard Precautions (e.g., hand hygiene, cough etiquette, PPE use) Review personnel records for evidence of training (initial, annual, with updates).
Sub-section F: Disaster Preparedness Plan							
5-F-1	A	B	C-M	C	There is a written protocol for a disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the facility.		Verify the facility's readiness to respond to disasters and emergencies, including: A comprehensive preparedness plan Biennial review/testing Staff competency <u>Key Requirements:</u> Emergency response procedures Staff roles/responsibilities Patient care continuity Resource management. <u>Evaluating Compliance:</u> Review the emergency preparedness plan for: Required elements Contact protocols Emergency procedures Review documentation for evidence of biennial review/updates and plan testing Interview staff regarding emergency responses/roles and plan accessibility

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Review personnel records for evidence of training (initial, annual, updates).
5-F-2	A	B	C-M	C	Facilities must conduct a biennial review and test of its disaster preparedness plan.		Verify the facility's readiness to respond to disasters and emergencies, by periodically reviewing and testing the procedures laid out in their disaster preparedness plan (DPP) Key Requirements: Review the DPP at least every two (2) years Test the plan at least every two (2) years Rotating scenarios (e.g., weather events, security events) Evaluation the effectiveness of the plan for the scenario tested Making changes (as necessary) to update the plan. <u>Evaluating Compliance:</u> Review documents for evidence of: Biennial review/testing of the DPP Evaluation after testing the plan Updates to the plan (if required).

SECTION 6: MEDICATIONS

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section A: Medications							
6-A-2	A	B	C-M	C	Drugs must be prepared and administered according to established policies and acceptable standards of practice.		Verify that drugs and biologicals used within the facility are administered in accordance with formally adopted facility policies, and that both the policies and the facility's actual practices conform to accepted professional practice and acceptable standards of medication administration (e.g., ISMP). The facility must maintain and implement policies and procedures designed to promote medication administration consistent with acceptable standards of practice. At a minimum, the policies and procedures should address: - Medication orders - Administration - Manufacturer's instructions - Timeliness of preparation - Labeling of pre-filled syringes - Infection control practices <u>Evaluating Compliance:</u> Review clinical record for medication order(s) are: - Signed by a qualified provider - Administered only by nurses or other qualified individuals, or under the supervision of nurses or other qualified individuals, as permitted under Federal, National or State law and the facility's policy - Determine whether medications are properly labeled, stored, and have not expired - Observe safe injection processes - Interview staff on medication administration processes and safe injection practices.
6-A-5	A	B	C-M	C	Outdated medications are removed and destroyed in accordance with federal/national, state, provincial, and local pharmacy regulations.		Verify the facility's medications are safe and effective, through proper expiration date management and storage compliance <u>Evaluating Compliance:</u> Review policies for: - Directive to comply with manufacturer's recommendations - Procedures to monitor for expirations and storage conditions

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Expired medication disposal process Review temperature logs for medication stored in refrigerators and freezers Interview staff regarding: - Checking expiration dates (how often) - Monitoring storage conditions - Disposal process Inspect medication storage areas (e.g., cabinets, carts, refrigerators) for: - Expiration dates (and cross-check with FDA extended use database, or equivalent national food and drug regulatory agency, when applicable) - Temperature and storage condition compliance per manufacturer's validated storage conditions.
6-A-6	A	B	C-M	C	Medications are stored in a secured area away from patient and visitor access.		Verify the facility's medications are secured, whilst maintaining emergency readiness <u>Evaluating Compliance:</u> Review policies for measures to maintain medication security and emergency drug access Interview staff regarding storage protocols and accessing emergency drugs Observe patient care to determine anesthesia medication security Verify controlled substances storage in substantial cabinets (per DEA 1301.75 or other relevant national drug enforcement agency) with restricted access Inspect medication storage areas for security breaches.
6-A-7	A	B	C-M	C	All drugs and biologicals given to patients must be approved by the physician/dentist with a signed order.		Verify the proper documentation of all medication orders to maintain patient safety and regulatory compliance <u>Evaluating Compliance:</u> Review policies for read-back verification process and requirement for prescriber to sign order promptly Interview staff regarding verbal order process Review clinical records for evidence of written, signed orders for all drugs/biologicals administered Confirm physician signatures follow verbal order documentation, especially in recovery.
6-A-8	A	B	C-M	C	The facility must provide drugs and biologicals in a safe and effective manner, in accordance with accepted		Verify the facility maintains adherence to professional standards for medication safety to prevent medication errors

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
					professional practice and under the direction of an individual designated responsible for pharmaceutical services.		<u>Evaluating Compliance:</u> Review policies for safe medication storage/preparation/administration/verbal order(VO) protocols Review documents for: Confirm designated pharmaceutical supervisor (pharmacist when required by state) Tracking medication errors/adverse drug reactions Interview staff regarding safety protocols (e.g., 5 rights, high-risk meds, VO) and error reporting Observe medication preparation/administration during patient care delivery Review personnel records for training on medication safety Review clinical records for evidence of: Written, signed orders for medications administered (especially VO in PACU) Medications administered in the sterile field.
Sub-section B: Intravenous Fluids							
6-B-1	A	B	C-M	C	Intravenous fluids such as Lactated Ringer's solution and/or normal saline are available in the facility, including intravenous (IV) administration sets, and various sizes of IV needles based on the patient population served.		Verify the immediate availability of IV fluids and administration sets for all patient populations served <u>Evaluating Compliance:</u> Interview staff regarding procedures for warming IV fluids Inspect storage of IV fluids/supplies to ensure the facility stocks an adequate inventory Confirm immediate access to IV fluids in emergency carts.
Sub-section C: Blood and Blood Substitutes							
6-C-1	A	B	C-M	C	If blood is administered in the facility, a protocol is present that addresses: typing; cross- matching; checking; verification; who may administer blood; and, patient monitoring requirements.		Verify the facility maintains stringent protocols to minimize the risks of infections, transfusion reactions, and circulatory overload associated with blood transfusions <u>Evaluating Compliance:</u> Review policies for inclusion of required elements Interview staff regarding pre-infusion checks, monitoring, and emergency responses Observe transfusion (if one occurs during the survey) to confirm compliance with the verification process and transfusion monitoring Review personnel records for training/competency Review clinical records for:

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Results from type/screen and cross-matching Evidence of two-person verification Baseline VS, first 15-minute direct observation, then strict transfusion monitoring Adverse reaction management.
6-C-3	A	B	C-M	C	The facility has the means for obtaining and administering blood or blood substitutes such as Dextran, if necessary.		Verify the facility has timely access to blood/blood products for transfusion when medically necessary. Evaluating Compliance: Review policies for written protocols regarding: Blood acquisition/transportation Emergency release of products Blood substitutes (if applicable) Massive transfusion Review documents for evidence of established relationships with blood banks and emergency suppliers Interview staff regarding emergency ordering process and turn around time Confirm availability of: O-negative blood (for emergency use) Blood typing supplies.
Sub-section D: Controlled Substances							
6-D-1	A	B	C-M	C	All controlled substances are secured and locked under supervised access. Storage of controlled substances must be in accordance with applicable federal/national, state/provincial, and local regulations.		Verify that the facility's controlled substances are securely stored in regulatory-compliant locked cabinets or approved emergency-use (e.g., crash cart) configurations with rigorous oversight, consistent with DEA, national or regional controlled-drug storage requirements. For facilities that have one (1) controlled substance, such as a benzodiazepine, the facility may develop and implement a policy and procedure to store the one (1) controlled substance securely in the facility's defined crash cart. In this case, the policy and procedure must include a process to check for outdated medication and to verify the medication's presence as part of the crash cart check. Evaluating Compliance: Review policies for: Storage method security requirements Regular substance accountability checks Outdated medication removal procedures Crash cart verification processes (if applicable)

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Observe all controlled substance storage for evidence of: - Substantial locked cabinets (per 21CFR §1301.75 or other national controlled substance storage requirement) - Crash cart storage (if single substance policy) Confirm no controlled substances in unsecured drawers Confirm documentation of access logs.
6-D-2	A	B	C-M	C	There is a dated controlled substance inventory and a control record that includes the use of controlled substances on individual patients. Such records must be kept in the form of a sequentially numbered, bound journal from which pages may not be removed, or in a tamper - proof, secure computer record consistent with state and federal law. This log must be kept in the facility.		Verify the facility reduces the risk of controlled substance (CS) diversion through comprehensive tracking from receipt to disposition with prompt discrepancy resolution and mandatory diversion reporting. <u>Evaluating Compliance:</u> Review policies and procedures for: - End-of-shift counts and discrepancy resolution - Diversion reporting (DEA/law enforcement/state boards/national authority that controls narcotics and psychotropic substances) Review CS records/logs to: - Confirm that a compliant controlled-substance tracking system (electronic or hardcopy) is in place, in accordance with the requirements of the DEA or the relevant national authority overseeing narcotics and psychotropic substances. - Validate sequential page numbering (if hardcopy) - Verify real-time reconciliation capability Review audit trail from receipt to: administration, destruction, and return Interview staff regarding process for ordering CS, receipt of inventory, and entering CS into stock Confirm designated pharmaceutical supervisor (e.g., consulting pharmacist if required by state).
6-D-3	A	B	C-M	C	All controlled substance transactions, including daily counts and wastes, require verification by two (2) licensed members of the team. (For facilities with only Schedule IV and V controlled substances, one (1) licensed and (1) authorized member of the operating room team may document verification of daily counts and wastes.) These verifications must be completed on any day that the facility is open and/or controlled substances are administered, and in compliance with federal/national, provincial, state, and local regulations. The facility must		Verify the facility reduces the risk of controlled substance (CS) diversion through verified inventory counts and waste documentation by qualified personnel. <u>Evaluating Compliance:</u> Review policies for: - Authorized personnel (licensed + facility-designated) with access - Count/waste verification requirements - Discrepancy resolution procedures Review CS recordkeeping to: - Ensure all transactions witnessed by one (1) of the following: - Two (2) licensed professionals (<u>OR</u>)

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					develop a policy detailing how unlicensed authorized individuals are authorized, if applicable.		One(1) licensed + one (1) authorized (in Class A facilities, Schedules IV-V only) Check for waste documentation Check for reconciliation of discrepancies Interview staff regarding count variance protocols Confirm corrective actions taken (when variances identified) Confirm diversion reporting to DEA or national authority that controls narcotics and psychotropic substances authorities (if identified).
Sub-section E: ACLS/PALS Algorithm							
6-E-5	A	B	C-M	C	There must be a written protocol for cardiopulmonary resuscitation (CPR). This protocol must include the provision for annual drills, staff training upon hire and annually, drill documentation, and retention of documentation for at least three (3) years.		Verify staff readiness to perform cardiopulmonary resuscitation through defined roles, annual training, and protocol maintenance. Drill content should vary in terms of time, location, and scenario. Drills and training are separate components. Not all staff are expected to participate in the scheduled drill, as staff may not be scheduled to work that day. <u>Evaluating Compliance:</u> Review policies to verify CPR/Code Blue protocols include drills, staff training, drill documentation, clear role assignments and define response team Interview staff regarding emergency activation, roles during code, use of emergency equipment/medications Review facility documentation for annual drill Review personnel records for CPR training (initial, annual, updates) and competency (BLS/ACLS certification).
Sub-section F: Emergency Medications							
6-F-1	A	B	C-M	C	All emergency medications, as noted, must be available and in the facility at all times. Licensed personnel in the facility must know their location.		Verify emergency medications and supplies are continuously available, immediately accessible, and that staff can rapidly locate them during crises. <u>Evaluating Compliance:</u> Review policies for definitions of minimum quantities based on patient volume and acuity Review checklists to ensure stock of the required drugs is regularly monitored Interview staff on monitoring protocols, restocking procedures, and minimum quantity requirements Inspect the stock to confirm all required emergency medications are

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							present (not expired) Confirm quantities are sufficient and medication are appropriate for the patient population served.
6-F-2	A	B	C-M	C	The following medication must be available in the facility at all times: IV Antihistamines (e.g. Diphenhydramine) – Minimum 50 mg.		Verify IV Antihistamines are continuously available, in the appropriate concentration and quantity for the patient populations served. <u>Evaluating Compliance:</u> Review checklists to ensure the stock of the required drug is regularly monitored Inspect stock for: IV Antihistamines (e.g. Diphenhydramine) Minimum dose 50 mg (not expired) Confirm quantities align with patient volume/acuity (pediatric dosing is present when applicable).
6-F-3	A	B	C-M	C	The following medication must be available in the facility at all times: Short-acting beta-blocker (e.g., esmolol or labetalol).		Verify a short-acting beta-blocker (e.g., esmolol or labetalol) is continuously available, in the appropriate concentration and quantity for the patient populations served. <u>Evaluating Compliance:</u> Review checklists to ensure the stock of the required drug is regularly monitored Inspect stock to verify that a short-acting beta-blocker (e.g., esmolol or labetalol) is present (not expired) Confirm quantities align with patient volume/acuity (pediatric dosing is present when applicable).
6-F-4			C-M	C	The following medication must be available in the facility at all times: Neuromuscular blocking agents including non-depolarizing agents such as rocuronium or depolarizing agents such as succinylcholine.		Verify emergency medications, specifically neuromuscular blocking agents, are stored appropriately to maintain potency and are continuously available, in the appropriate concentration and quantity for the patient populations served. <u>Evaluating Compliance:</u> Review checklists to ensure the stock of the required drug is regularly monitored Review temperature logs for consistent monitoring and corrective action for temperature variances Inspect stock to verify that neuromuscular blocking agents are present (not expired) and stored according to the manufacturer's specifications: Succinylcholine: Refrigerated: (preferred) storage at 2° - 8°C (36° - 46°F)

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							Room temp: labeled when removed from refrigeration (manufacturer/container specific) Rocuronium Bromide: Refrigerated: storage at 2°- 8°C (36°- 46°F) Room temp: labeled when removed from refrigeration & used within 60 days; opened vials within 30 days Interview staff on storage requirements and expiration date management.
6-F-5		B	C-M	C	The following medication must be available in the facility at all times: If a Benzodiazepine is used in the facility, a reversal agent must be available (e.g. Mazicon™, Flumazenil).		Verify reversal agents (e.g., naloxone for opioids, flumazenil for benzodiazepines) are continuously available, in the appropriate quantity for the patient populations served. <u>Evaluating Compliance:</u> Review checklists to ensure stock of the required drug is regularly monitored Inspect stock to verify that reversal agents (e.g., naloxone, flumazenil) are present (not expired) Confirm quantities align with patient volume/acuity (pediatric dosing is present when applicable).
6-F-6	A	B	C-M	C	The following medication must be available in the facility at all times: Vasopressors other than epinephrine (e.g. Ephedrine).		Verify vasopressors (other than epinephrine) are continuously available, in the appropriate concentration and quantity for the patient populations served. <u>Evaluating Compliance:</u> Review checklists to ensure stock of the required drug is regularly monitored Inspect stock for vasopressors (e.g., ephedrine, phenylephrine, norepinephrine) (not expired) Confirm quantities align with patient volume/acuity (pediatric dosing is present when applicable).
6-F-8	A	B	C-M	C	The following medication must be available in the facility at all times: Bronchospasm-arresting medication (inhaled beta-agonist, e.g. albuterol).		Verify bronchospasm-arresting medication (inhaled beta-agonist) is continuously available, in the appropriate concentration and quantity for the patient populations served. <u>Evaluating Compliance:</u> Review checklists to ensure stock of the required drug is regularly monitored Inspect stock for bronchospasm-arresting medication (e.g., albuterol) (not expired)

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Confirm quantities align with patient volume/acuity (pediatric dosing is present when applicable).
6-F-9	A	B	C-M	C	The following medication must be available in the facility at all times: Anti-hypertensives		Verify anti-hypertensive medications are continuously available, in the appropriate concentration and quantity for the patient populations served. Evaluating Compliance: Review checklists to ensure stock of the required drug is regularly monitored Inspect stock for anti-hypertensive medications (not expired) Confirm quantities align with patient volume/acuity (pediatric dosing is present when applicable).
6-F-10	A	B	C-M	C	The following medication must be available in the facility at all times: Seizure-arresting medication (a benzodiazepine, e.g. Midazolam).		Verify seizure-arresting medications (benzodiazepines) are continuously available, in the appropriate concentration and quantity for the patient populations served. First-line seizure-arresting medications are fast-acting medications that include lorazepam, diazepam, clonazepam, and midazolam (IV or nasal spray). Phenytoin is not considered a first-line seizure-arresting medication; it is a second-line medication used for established status epilepticus (20 – 40 minutes). While phenobarbital is still used for seizure treatment, it's not generally considered a first-line medication for most adults or in many developed countries. It is often not possible to take a medication by mouth during a seizure, and the medications used for emergency management of seizures are available in forms that can be injected into a muscle (IM), administered intravenously (IV, in a vein), used as a nasal spray, or administered rectally. Evaluating Compliance: Review checklists to ensure stock of the required drug is regularly monitored Inspect stock for seizure-arresting medications (e.g., midazolam) (not expired) Confirm quantities align with patient volume/acuity (pediatric dosing is present when applicable).

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6-F-11	A	B	C-M	C	The following medication must be available in the facility at all times: Intravenous corticosteroids (e.g., dexamethasone).		Verify intravenous corticosteroids are continuously available, in the appropriate concentration and quantity for the patient populations served. <u>Evaluating Compliance:</u> Review checklists to ensure stock of the required drug is regularly monitored Inspect stock for intravenous corticosteroids (e.g., dexamethasone) (not expired) Confirm quantities align with patient volume/acuity (pediatric dosing is present when applicable).
6-F-12	A		C-M	C	Facilities administering regional or tumescent anesthesia containing bupivacaine must always have 20% lipid emulsion available.		Verify 20% lipid emulsion is continuously available for the immediate treatment of Local Anesthetic Systemic Toxicity. <u>Evaluating Compliance:</u> Determine the need for stock of 20% lipid emulsion through staff interviews or a review of clinical records Review checklists to ensure stock of the required drug is regularly monitored Inspect stock for 20% lipid emulsion (not expired) Confirm quantities align with patient volume (pediatric dosing is present when applicable).
6-F-13	A	B	C-M	C	The following medication must be available in the facility at all times: A narcotic reversal agent (e.g., naloxone, nalmeferene).		Verify narcotic reversal agents (e.g., naloxone, nalmeferene) are continuously available, in the appropriate quantity for the patient populations served. <u>Evaluating Compliance:</u> Review checklists to ensure stock of the required drug is regularly monitored Inspect stock for narcotic reversal agents (e.g., naloxone, nalmeferene) (not expired) Confirm quantities align with patient volume (pediatric dosing is present when applicable).
Sub-section G: Malignant Hyperthermia							
6-G-1			C-M	C	If the depolarizing muscle relaxant succinylcholine is present only for use in emergency airway rescue, the facility must document a protocol to manage the possibility of malignant hyperthermia (MH) following its use, and staff training must occur on hire and then annually.		Verify that facilities keeping only a limited stock of paralytic agents for use in emergency airway rescue maintain these essential requirements: Storage of a MH-triggering, depolarizing neuromuscular blocking agent (succinylcholine) requires:

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							Written MH policy MHAUS algorithm on the emergency cart Staff training Storage of a non-depolarizing neuromuscular blocking agent (e.g., rocuronium, vecuronium) requires: MHAUS algorithm on the emergency cart Staff training. <u>Evaluating Compliance:</u> Determine the facility's use of MH-triggering agents (e.g., isoflurane, sevoflurane, desflurane, succinylcholine) through: Staff interviews Confirmation with review of recent anesthesia records Review policy for alignment with MHAUS guidelines (for storage of Succinylcholine only) Interview staff regarding knowledge of MH signs/symptoms, MH protocols, and location of MHAUS algorithm Inspect the emergency cart to confirm current MHAUS algorithm is present Review personnel records for evidence of training (initial, annual).
6-G-2			C-M	C	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: Screening for MH risk must be documented, that includes but is not limited to a family history of unexpected death(s) following general anesthesia or exercise; a family or personal history of MH, a muscle or neuromuscular disorder, high temperature following exercise; a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise.		Verify that patients are screened for risk of malignant hyperthermia (MH) whenever drugs that can trigger MH are available or used, so that an MH-susceptible patient is identified before anesthesia is administered, preventing a potentially fatal reaction. <u>Evaluating Compliance:</u> Determine facility use/storage of MH triggering agents (e.g., isoflurane, sevoflurane, desflurane, succinylcholine) through staff interviews and confirmation from clinical record review Review policies for alignment with MHAUS guidelines Review screening process for inclusion of: Personal/family history of MH or adverse anesthetic reactions Assessment for associated conditions (e.g., central core disease, other myopathies) Interview staff on screening questions and actions needed for patients with increased risk (e.g., avoidance of triggering agents, use of a "clean" machine, prolonged monitoring) Review clinical records for evidence of: MH-risk screening for all patients Precautions taken for at-risk patients.

Standard ID	Class			Standard Language	Regulation	Interpretive Guidance
6-G-5			C-M	C		Verify all clinical staff are trained and prepared to manage a malignant hyperthermia (MH) crisis. Annual MH drills are required unless triggering agents are present only for emergency airway rescue (e.g., succinylcholine) Note: Drills and training are separate components. Not all staff are expected to participate in the scheduled drill, as staff may not be scheduled to work that day. Evaluating Compliance: Determine facility use/storage of MH triggering agents (e.g., isoflurane, sevoflurane, desflurane, succinylcholine) through staff interviews and confirmation from clinical record review Review MH drill protocol for inclusion of roles, responsibilities, and simulation of dantrolene preparation Review evidence of MH Drill (date, participants, dantrolene reconstitution) (when applicable) Interview staff (including contractors) to assess: Understanding of MH signs/symptoms Knowledge of dantrolene/ryanodex dosing and administration Clarity of individual roles during a crisis Awareness of MH Hotline: 1-800-644-9737, outside of North America 001-209-417-3722 Review personnel records to confirm MH training (initial, annual) for all clinical staff (if drills required).
6-G-6			C-M	C		Verify all medications and supplies required to manage a malignant hyperthermia (MH) crisis are immediately available and accessible. This includes an adequate supply of the correct diluent (sterile water for injection) for dantrolene or ryanodex. Evaluating Compliance: Inspect MH crisis supply storage area to confirm the minimum supply of sterile water (for injection): For Dantrolene, at least 720 mL sterile water is available (60 mL per vial for 12 vials, more for full dosing) For Ryanodex, at least 15 mL of sterile water for injection is available (5 mL per vial for 3 vials) Confirm MH crisis supplies are stored together for immediate access, clearly labeled, and not expired.
6-G-7			C-M	C		Verify all medications and supplies required to manage a malignant hyperthermia (MH) crisis are immediately available and accessible.

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					depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: A minimum of 4 ampoules, 50cc's each, of sodium bicarbonate (NaHCO ₃).		This includes sufficient quantities of sodium bicarbonate to treat severe acidosis. Evaluating Compliance: Inspect MH crisis supply storage area to confirm at least four (4) 50 mL vials of sodium bicarbonate (NaHCO₃) are present Confirm MH crisis supplies are stored together for immediate access, clearly labeled, and not expired.
6-G-8			C-M	C	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: A minimum supply of dantrolene/Ryanodex should be stocked to treat a patient of average weight (approximately 70kg) with an initial dose: Dantrium®/Revonto® - 12 vials (20 mg/vial) Ryanodex® - 1 vial (250 mg/vial).		Verify all medications and supplies necessary to manage a malignant hyperthermia (MH) crisis are readily accessible to support a positive patient outcome. Readily accessible, in this instance, means the facility is able to administer Dantrolene/Ryanodex within 10 minutes of the first sign of MH. Evaluating Compliance: Inspect MH crisis supply storage area to confirm a minimum supply of Dantrolene (12 vials) or Ryanodex (1 vial) is present (not expired).
6-G-9			C-M	C	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: An additional* supply of dantrolene/Ryanodex and diluents are stored in the facility, or the facility has a written agreement with another source that will provide additional* dantrolene/Ryanodex and diluents on a STAT basis within 10 minutes for continued treatment and stabilization of a patient experiencing a MH episode. *Additional supply of dantrolene is defined as: Dantrium®/Revonto® - 24 vials (20 mg/vial) Ryanodex® - 2 vial (250 mg/vial)		Verify an additional supply of dantrolene/ryanodex and diluent are obtainable within ten (10) minutes to sustain treatment during a prolonged malignant hyperthermia (MH) crisis. This supply may be maintained on-site or via a formal, written agreement with a reliable external source. Note: Compliance with this standard is not required if succinylcholine is present only for emergency airway rescue. Evaluating Compliance: Inspect MH crisis supply storage area to confirm additional dantrolene (24 vials) or ryanodex (2 vials) and adequate diluent is present (not expired) If additional supply is available via external agreement: Confirm agreement is with a reliable source (e.g., hospital pharmacy, other facility) that is quickly accessible Review drill documentation Interview staff to determine if timely receipt of additional medications/supplies has been verified During survey, staff must request the immediate delivery of the additional medications/supplies Time the process (from phone request to arrival of medications/supplies) to verify timeframe is met.

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6-G-10			C-M	C	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: Flow sheets for any MH intervention as well as forms to rapidly communicate the progress of intervention with receiving facilities are on the emergency cart, and the facility must document and report any "adverse metabolic or musculoskeletal reaction to anesthesia". This documentation must be transportable with the patient when transferred to the receiving facility.		Verify the facility has the ability to produce clear, timely, and transportable documentation of all malignant hyperthermia (MH) crisis interventions to support patient handoff and continuity of care at a receiving facility. Note: Compliance with this standard is not required if succinylcholine is present only for emergency airway rescue. <u>Evaluating Compliance:</u> Review policies for directives related to patient's having a MH crisis: Adverse metabolic or musculoskeletal reactions to anesthesia are reported to receiving facility MH flowsheet must accompany patient to receiving facility for handoff Review the MH flowsheet standardization for: Timelines for key actions (e.g., dantrolene administration, cooling measures) Patient vital signs and metabolic status (e.g., ETCO₂, temperature, acidosis) Confirm presence of blank MH flowsheets on the emergency cart Review relevant clinical records to ensure flowsheets are present, complete, and accurate.

SECTION 7: INFECTION PREVENTION AND CONTROL

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Sub-section A: Infection Prevention and Control							
7-A-10	A	B	C-M	C	The facility's policies address operating/procedure room attire. This includes scrub suits, caps or hair covers, gloves, operative gowns, masks, eye protection, and all other appropriate attire based on the procedure being conducted.		Verify the facility minimizes infection risk by ensuring proper surgical attire is worn in semi-restricted and restricted areas, and that all attire is laundered under controlled conditions to meet hygienic standards. Evaluating Compliance: Review policies for alignment with adopted nationally recognized guidelines (e.g., CDC, WHO, AORN) for: Surgical attire requirements (e.g., disposable caps, scrubs, shoe covers) Laundering processes (e.g., healthcare-accredited or in-house per standards) Restrictions (e.g., home laundering, wearing scrubs outside facility) When scrub attire is laundered onsite, review documents confirming processes meet thermal, mechanical, and chemical standards to reduce microbial load Observe staff in semi-restricted/restricted areas for proper surgical attire (e.g., scrubs, caps, masks).
7-A-11	A	B	C-M	C	A sterile field is used during all operations and procedures, as applicable.		Verify the facility minimizes infection risk by ensuring a sterile field is established/maintained for all applicable procedures and adhering to aseptic technique standards. Evaluating Compliance: Review policies for alignment with nationally recognized guidelines (e.g., CDC, WHO, AORN) to ensure sterile field protocols are maintained Interview staff regarding creation/maintenance of sterile field and action when breaches are noted Observe procedures to verify: Sterile technique is established/maintained throughout (e.g., proper draping, no breaches) Staff adhere to principles of asepsis (e.g., avoiding non-sterile contact).
7-A-12	A	B	C-M	C	The facility staff must have knowledge of infection prevention and control techniques.		Verify the facility provides training on the infection prevention and control protocols key to supporting safe patient care and protecting staff.

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							<u>Evaluating Compliance:</u> Review training materials for: Alignment with current, recognized infection prevention and control guidelines Adequacy to address the services provided by the facility and the risks to patients, staff, and guests (e.g., infection prevention and control surveillance, standard precautions, environmental cleaning, disinfection and sterilization) Interview staff regarding knowledge of procedures to prevent and control the spread of infection Review personnel files for evidence of training (initial, annual, updates).
7-A-13	A	B	C-M	C	Reuse of single-use disposable biopsy forceps is strictly prohibited. Purchase records must be retained for three (3) years and available for comparison to procedural and pathology specimen logs.		Verify the facility complies with the manufacturer's designation of single-use for disposable biopsy forceps. <u>Evaluating Compliance:</u> Review documents and cross-check: Volume from purchase orders of single-use biopsy forceps Volume of use in procedure logs Interview staff regarding process for identifying manufacturer's designation Observe staff during procedures to confirm single-use items are properly disposed Confirm purchasing records for disposable biopsy forceps are available for the past three (3) years.
7-A-14	A	B	C-M	C	Policy and practices exist to prevent and control infections such as: proper use of antibiotics, hand hygiene, prevention of site infection, and infection event reporting.		Verify the facility implements comprehensive infection prevention and control policies and procedures. <u>Evaluating Compliance:</u> Review policies for: Evidence of annual review/updates Alignment with current infection prevention and control guidelines Adequacy to address the services provided by the facility and the risks to patients, staff, and guests (e.g., infection prevention and control surveillance, standard precautions, environmental cleaning, equipment disinfection, sterilization of patient care devices) Observe staff for compliance with the facility's policies.
7-A-15	A	B	C-M	C	Aseptic techniques are maintained during procedures and between cases.		Verify that facility staff maintain strict compliance with approved techniques to prevent the introduction of microorganisms and minimize the risk of infection, protecting both patients and healthcare

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							workers. <u>Evaluating Compliance:</u> Review policies for procedures that: Align with current infection prevention and control guidelines Are adequate to address the services provided by the facility and the risks to patients, staff, and guests (e.g., infection surveillance, standard precautions, environmental cleaning, equipment disinfection, sterilization) Interview staff regarding knowledge of aseptic technique Observe staff for compliance with facility policies.
Sub-section B: Hand Hygiene							
7-B-1	A	B	C-M	C	Hand hygiene is performed in accordance with current nationally recognized and/or WHO guidelines and standards of practice. Periodic hand hygiene auditing must be a part of the facility's quality activities. For surgical/procedural facilities: Scrub facilities are provided for the operating room staff. Scrub products (as appropriate), soap, and alcohol cleansers are provided for the operating room staff, consistent with current adopted guidelines and standards of practice for hand hygiene.		Verify the facility minimizes infection risk through rigorous hand hygiene protocols that align with CDC/WHO guidelines, including: Surgical hand antisepsis Routine hand hygiene (HH) audits Maintaining accessible HH supplies. <u>Evaluating Compliance:</u> Review policies for alignment with adopted national guidelines (e.g., CDC, WHO) Confirm HH policies define audit frequency, methods, and QAPI integration Review documentation of HH audit records for: Regular, unannounced observations Compliance with "WHO Five Moments" (e.g., before patient contact, after environmental contact) Data analysis, feedback, and documented corrective actions HH audits results integration into the facility's QAPI program Interview staff regarding indications for HH and surgical scrub protocols (e.g., brushless technique, duration) Observe practices for adherence during patient care and procedures Inspect facility to ensure alcohol-based hand rub, surgical scrub supplies, and sinks are: Readily accessible in semi-restricted/restricted areas (not expired) Separate from instrument cleaning sinks.
Sub-section C: Instrument Processing							
7-C-1	A	B	C-M	C	The facility has a written protocol for the reprocessing of all surgical instruments and disinfection of all equipment used		Verify the facility minimizes infection risk by ensuring all reusable instruments and equipment are reprocessed or disinfected according to manufacturer instructions for use (IFU) and nationally recognized

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					in patient care consistent with the manufacturer's instructions for use.		guidelines. This applies to all equipment used in patient care, including point-of-care devices. Contracted reprocessing services must be rigorously monitored through the facility's quality improvement program. <u>Evaluating Compliance:</u> Review policies for: Alignment with recognized guidelines (e.g., CDC, AORN, AAMI, WHO) Directive for strict adherence to manufacturer's IFU for all equipment HLD/sterilization procedures and recordkeeping criteria Interview staff regarding ophthalmic instrument reprocessing to prevent TASS and endophthalmitis: Cleaning intraocular instruments in a designated area, separate from general surgical instruments Importance of rinsing/flushing phaco handpieces and cannulas (single-use preferred) Observe staff to ensure: Cleaning/reprocessing occur in between patients use or when contaminated Manufacturer's IFU are strictly followed for high-level disinfection or terminal sterilization Cleaning agents (e.g., enzymatic) and methods (e.g., ultrasonic cleaning) align with IFU Thorough rinsing, flushing, drying occur before disinfection/sterilization Review personnel records for validation of competency (initial, per policy, updates) If the facility uses contracted services for reprocessing: Confirm written contract holds vendor accountable to meet all applicable standards (e.g., ANSI/AAMI ST79) Confirm annual contract review is part of the facility's QAPI program, with a defined process for validating the vendor's compliance, staff competence, and quality outcomes.
7-C-2	A	B	C-M	C	There is strict segregation of dirty surgical equipment and instruments that have been cleaned and are in the preparation and assembly area.		Verify the facility prevents cross-contamination and minimizes infection risk by ensuring a unidirectional workflow (clean to dirty) and adherence to national industry standards for reprocessing instruments. <u>Evaluating Compliance:</u> Inspect work areas for evidence that clean instruments/equipment are

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							stored away from contaminated instruments/equipment Confirm workflow between the two (2) areas is unidirectional (clean → dirty).
7-C-3	A	B	C-M	C	The instrument preparation and assembly area (clean processing area) are separated by walls or space from the instrument cleaning and decontamination area (reprocessing area).		Verify the facility prevents cross-contamination and minimizes infection risk by maintaining strict physical separation between clean and dirty processing areas. Evaluating Compliance: Inspect work areas for evidence of separation between dirty and clean work areas, confirming one (1) of the following: A physical barrier (e.g., work areas are in different rooms with a pass-through) A screen barrier is in place (extending ≥4 feet above the sink's rim) Minimum 4-foot distance separating the decontamination sink (dirty area) from the clean processing area Confirm workflow between the two (2) areas is unidirectional (clean → dirty).
7-C-4	A	B	C-M	C	Single-use devices are not reprocessed unless they are approved by the FDA for reprocessing. Reprocessing of these devices is done by an FDA-approved reprocessor. NOTE: The FDA requirement does not apply to international facilities. International facilities must comply with local, state/provincial or federal/national requirements regarding reprocessing single-use devices.		Verify the facility minimizes infection risk by strictly following the manufacturer's designation for use. When a device is approved for a limited number of sterilization cycles, the facility must have a documented tracking process and ensure limits are not exceeded. Items lacking manufacturer's cleaning/reprocessing instructions are usually single-use (disposable) Note: Reprocessing single-use devices is only allowed when FDA-approved and the device manufacturer provides approved methods and validated reprocessing instructions for third party reproducers. Evaluating Compliance: Review policies for: Directive to comply with manufacturer's designation for use (e.g., reusable, limited use, single-use only) Prohibition to reprocess single-use devices <u>unless</u> FDA/manufacturer approved by third party reprocessor Requirement to adhere to manufacturer instructions for use (IFU) for any approved reprocessing Interview staff to assess knowledge of: Which devices are strictly single-use Reprocessing protocols and cycle limits for approved devices For reusable devices approved for a limited number of sterilization cycles (e.g., gel implant sizers, LMAs, some liposuction cannulas):

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							Review documentation for device identification and traceability to confirm: - Number of reprocessing cycles (e.g., ≤ 10 for gel sizers, ≤ 40 for LMAs) - Reprocessing follows IFU exactly - Saline breast implant sizers are never reprocessed.
Sub-section D: Sterilization							
7-D-1	A	B	C-M	C	All instruments used in patient care are sterilized, where applicable.		Verify the facility minimizes infection risk by ensuring critical equipment (e.g., surgical instruments) is sterilized using validated processes, and semi-critical equipment (e.g., laryngoscope blades, LMAs) undergoes high-level disinfection or sterilization per the manufacturer's instructions for use (IFU). Documentation must verify sterilization parameters were achieved for each load. <u>Evaluating Compliance:</u> Review policies for alignment with recognized infection prevention and control guidelines (e.g., CDC, AORN, AAMI, WHO) Review sterilization records to confirm: - Physical parameters for sterilization (time/temp/pressure) per manufacturer IFUs were actually achieved - Extended parameters were achieved for complex instrumentation/devices - Results of chemical indicators, biological indicators were assessed Observe reprocessed devices to confirm: - Critical items are terminally sterilized - Semi-critical items receive high-level disinfection or sterilization consistent with manufacturer's IFU - Correct cycle selection based on manufacturer's IFUs (and packaging) Review personnel files for evidence of competency for staff responsible for reprocessing: - Competency validation (initial, periodically according to facility policy) If the facility does not have a sterilizer onsite, and sterilization is performed by an external vendor: - Confirm written contract holds vendor accountable to meet all applicable standards (e.g., ANSI/AAMI ST79) - Review documentation proving sterilization was performed appropriately.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
7-D-2	A	B	C-M	C	The facility has at least one (autoclave) that uses high-pressure steam and heat, or all sterile items are single-use disposable, or the facility has contracted with an outside vendor to process instruments, if applicable. Instrument reprocessing and sterilization must follow the manufacturer's instructions for use.		Verify the facility minimizes infection risk by ensuring all reusable instruments are reprocessed according to the manufacturer's instructions for use (IFU), either by prompt sterilization onsite or via the services of an external vendor. Contracted reprocessing services must be rigorously monitored through the facility's quality improvement program. Evaluating Compliance: When the facility reprocesses instrumentation onsite, confirm functional sterilizer(s) in use Observe staff to ensure: Manufacturer's IFU are strictly followed for high-level disinfection or terminal sterilization, including: Treatment, cleaning agents (e.g., enzymatic) & methods (e.g., ultrasonic cleaning) align with IFU Thorough flushing, rinsing, and drying occur before sterilization Review personnel records for validation of competency (initial, per policy, updates) If the facility uses contracted services for reprocessing, confirm: Written contract holds vendor accountable to meet all applicable standards (e.g., AAMI ST79) Annual contract review is part of the facility's QAPI program, with a defined process for validating the vendor's compliance, staff competence, and quality outcomes.
7-D-3	A	B	C-M	C	Additional methods in use can be chemical (Chemclave®) or gas (ethylene oxide/EO) sterilizer.		Verify the safe and effective use of chemical sterilizers (e.g., ethylene oxide, chemical vapor) to minimize infection risks and staff exposure to hazardous agents. Strict adherence to manufacturer instructions and staff competency are critical due to the complexity and potential dangers of these systems Note: Chemical sterilizers require rigorous safety protocols due to hazardous agents; facilities should prioritize steam sterilization when feasible. Evaluating Compliance: Review policies for alignment with manufacturer instructions for use (IFUs), including: Physical parameters (time, temperature, pressure, gas concentration) Safety protocols for handling hazardous chemicals (e.g., EtO, formaldehyde) Aeration requirements and exposure limits

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Interview staff regarding PPE use and emergency procedures for leaks or exposures Observe practices to confirm: - Proper use of PPE (e.g., respirators, gloves) during loading/unloading - Adequate ventilation and monitoring for hazardous gas levels - Validation/documentation of cycle parameters (e.g., time, temperature, gas concentration) Review personnel files for evidence of: - Training (initial, annual, updates) on chemical sterilizer or AED operation/safety - Validation of competency (initial, ongoing per facility policy).
7-D-4	A	B	C-M	C	Gas sterilizers and automated endoscope re-processors (AER) must be vented and tested for occupational exposure in accordance with the manufacturer's specifications.		Verify the safe and effective use of gas sterilizers and automated endoscope reprocessors to protect staff from occupational exposure to hazardous agents. <u>Evaluating Compliance:</u> Review policies for alignment with manufacturer instructions for use (IFU), including: - Safety protocols for handling hazardous chemicals (e.g., EtO, formaldehyde) - Aeration requirements and exposure limits (when applicable) - Maintenance, safety testing, and validation protocols Review documents for evidence of: - Testing for hazardous gas/chemical exposure per IFU - Corrective actions if exposure limits are exceeded Interview staff regarding PPE use and emergency procedures for leaks/exposures Observe practices to confirm: - Use of PPE (e.g., respirators, gloves) and engineering controls (e.g., ventilation, closed-system transfer) - Adequate ventilation and monitoring
7-D-5	A	B	C-M	C	The facility monitors the sterilization cycle's effectiveness in accordance with nationally and internationally recognized standards of practice and in conjunction with the manufacturer's instructions for use. This includes but is not limited to: - Monitoring each sterilizer load for the appropriate mechanical indicators (e.g., time, temperature, and pressure); - Using type 1 (external) and type 5 (internal) chemical indicators;		Verify the facility minimizes infection risk by ensuring the sterilization process for critical equipment adheres to the manufacturer's instructions for use (IFU) and is rigorously monitored. <u>Evaluating Compliance:</u> Review policies for alignment with AAMI ST79 or equivalent International sterile processing and steam sterilization standards, and manufacturer's IFU (device specific) Review sterilization recordkeeping, for inclusion of: Sterilizer identification and cycle type (e.g., wrapped)

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
					- Weekly biological indicator (spore test) for each sterilizer; - Using a biological indicator for every load containing implantable items; and. - Recording evidence of sterilization assurance monitoring for every load, and any corrective action is documented.		Load contents, control number Device-specific physical monitors (time, temperature, pressure) were met (by printout or manual log) Assessment of chemical indicators Results of biological indicators (at least weekly, mandatory with any load containing implants) Operator ID Interview staff regarding sterilizer operation and response to indicator failures/parameter deviations Observe staff for correct chemical indicator placement and interpretation Confirm chemical indicators are used per manufacturer recommendations: External: Type 1 tape/labels on every package or rigid container Internal: Type 5 (integrating) indicators inside packs/containers Bowie-Dick: Type 2 daily testing for dynamic-air-removal sterilizers.
7-D-6	A	B	C-M	C	Sterile instruments and supplies are packaged according to the manufacturer's instructions for use (IFU) and sealed effectively. Self-sealing peel pouches must be folded on the crease and may only be double-pouched when the process is validated by the manufacturer.		Verify sterile instruments are packaged safely and consistently with manufacturer instructions to minimize infection risks. Proper packaging, sealing, and labeling are critical to maintaining sterility until point of use. <u>Evaluating Compliance:</u> Review policies to ensure they require: Use of FDA-cleared packaging materials Adherence to manufacturer's instructions for use (IFU) for packaging Interview staff regarding instrument positioning (open vs. closed) and evaluating compromised packages Inspect a variety of sterilized packages to ensure packages: Are not overfilled (allowing penetration of sterilant) Contain hinged instruments in open, unlocked position Are sealed effectively (no gaps or compromised seals) Are only double-pouched if validated by the manufacturer (with the inner pouch unfolded).
7-D-7	A	B	C-M	C	Each sterilized pack is labeled with the date of sterilization and, when applicable, with the expiration date. When the facility has more than one sterilizer, labels must also identify the sterilizer used.		Verify sterilized instrument packages are clearly and accurately labeled to maintain sterility, support tracking, and enable recall if needed. <u>Evaluating Compliance:</u> Interview staff regarding expiration date protocols (e.g., event-related, time related) and recall process

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Inspect sterile packages for, at a minimum, labeling requirements that include: - Sterilizer identification (if more than one in use) - Cycle or load number identification - Date of sterilization and - Expiration date (if applicable based on packaging IFU) - Initials of staff that prepared the package - Number of re-sterilizations (if applicable for reprocessed devices approved for a limited number of cycles) Confirm labels are affixed securely and do not compromise packaging integrity (e.g., no punctures or adhesive over seals).
7-D-9	A	B	C-M	C	Comprehensive monitoring records that include quality control are retained for the sterilization or other disinfection process and should be reviewed and stored for a minimum of three (3) years.		Verify sterilization processes are monitored to confirm sterility assurance and comprehensive records are maintained to support traceability and recall efforts. Note: Logs must be retained per facility policy (typically ≥3 years). Electronic record systems must ensure data integrity and accessibility. <u>Evaluating Compliance:</u> Review policies for the number of years sterilization records must be kept Review documents for evidence of comprehensive recordkeeping, including: - Sterilizer identification and cycle type (e.g., wrapped) - Load contents, control number - Device-specific physical monitors (time, temperature, pressure) were met (by printout or manual log) - Assessment of chemical indicators - Results of biological indicators (at least weekly, mandatory with loads containing implants) - Operator ID Review documents for evidence of tracking process for the number of re-sterilizations when applicable (e.g., reusable LMA, breast implant sizers, some liposuction cannulas).
7-D-10	A	B	C-M	C	There is a written policy and procedure for the management of a positive biological indicator.		Verify positive biological indicators are managed promptly and effectively to mitigate infection risks. Facilities must have protocols for tracking, recalling, and reprocessing instruments exposed to a failed sterilization cycle. <u>Evaluating Compliance:</u> Review policies for procedures that align with the facility's adopted recognized infection prevention and control guidelines and the

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							manufacturer's IFU for the biological indicator (BI) to include: - Immediate steps to take upon a positive BI (e.g., remove sterilizer from use, ASAP repeat BI testing, etc.) - Procedures for investigating the cause (e.g., mechanical failure, operator error) - Protocols for recalling/reprocessing affected instruments Review documents for records of past BI failures: - To confirm response effectiveness and compliance with policy timelines - To ensure recalled instruments are reprocessed - Affected sterilizer was not used until repaired, challenged, and cleared for use Interview staff regarding positive BI management protocols and recall process.
7-D-11	A	B	C-M	C	Immediate use steam sterilization (IUSS) is not done on a routine or frequent practice.		Verify the facility minimizes infection risk by restricting Immediate-Use Steam Sterilization (IUSS) to emergency situations only. IUSS is not a substitute for inadequate instrument inventory or planning. Strict documentation and compliance with manufacturer instructions are required to ensure patient safety. Evaluating Compliance: Review policies for directives to: - Limit IUSS to validated emergencies (e.g., dropped instrument) - Complete all cleaning steps per the manufacturer's IFU - Use only IUSS-approved containers Review IUSS records for evidence of: - Frequency and justification (e.g., emergency, contaminated item) - Evidence of misuse (e.g., routine use due to insufficient instruments) Interview staff regarding acceptable IUSS scenarios and documentation requirements Observe IUSS practices (if occurring) for compliance with manufacturer IFUs and aseptic techniques Confirm IUSS is not used for: - Implants (unless documented emergency with no alternative) - Prion-related contamination - Non-validated cycles.
Sub-section E: High-Level Disinfection (HLD)							
7-E-1	A	B	C-M	C	High-level disinfection is performed upon heat-sensitive endoscopic equipment and other medical devices classified		Verify the facility minimizes infection risk by ensuring semi-critical equipment undergoes high-level disinfection (HLD) or sterilization with strict adherence to the manufacturer's instructions for use (IFU). HLD

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					as semi-critical, but only when recommended by the manufacturer's instructions for use (IFU).		chemicals must be monitored and replaced per manufacturer recommendations Note: Prioritize sterilization over HLD for rigid scopes when feasible. <u>Evaluating Compliance:</u> Review policies for: Alignment with recognized infection prevention and control guidelines Directive to follow IFU for each device (e.g., flexible endoscopes, laryngoscope blades) Review processing logs for evidence of: HLD/sterilization cycles (e.g., time, temperature, chemical concentration) align with IFU Testing of disinfectant efficacy (e.g., minimum effective concentrations) Traceability of devices to patients (in case of failure) Interview staff regarding: Definition of semi-critical devices Device-specific IFUs (e.g., immersion time, concentration, rinse steps for HLD) Handling and storage post-processing to prevent recontamination.
7-E-2	A	B	C-M	C	Endoscopes are processed in accordance with a written policy and procedure consistent with recognized guidelines and standards of practice. The policy must address how scopes are treated at the point of use, transported, cleaned, high-level disinfected, and stored.		Verify the facility maintains compliance with comprehensive policy to ensure flexible endoscopes are reprocessed according to current recognized infection prevention and control guidelines and device-specific manufacturer's instructions for use (IFU). Staff competency must be validated. <u>Evaluating Compliance:</u> Review policies for: Recognized infection prevention and control guidelines the facility has adopted Point-of-use pre-cleaning (immediately post-procedure to prevent biofilm) Leak testing (after use, before manual cleaning) Manual cleaning (brushing/flushing channels within IFU-specified timeframes) Definition of "delayed processing" with additional steps (e.g., extended cleaning) Visual inspection (using magnification) High-level disinfection (using validated chemicals and equipment) or sterilization process Storage (vertical hanging or horizontal per IFU, ≥3 feet from sinks)

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							Review documents for evidence of: - Disinfectant testing (minimum effective concentration) - HLD parameters being met (printouts) - Scope identification, patient traceability, and operator initials - Automated endoscope reprocessor (AER) maintenance Observe staff regarding reprocessing steps, timing constraints, PPE use Review personnel files for validation of competency for manual cleaning, AER operation, and chemical handling.
Sub-section F: Cleaning							
7-F-2	A	B	C-M	C	The entire operating room suite is cleaned and disinfected according to an established facility policy and procedure, based on industry standards, and includes, at a minimum: - Cleaning schedule - Process for cleaning between cases - Process for terminal cleaning after the last case of the day - Use of intermediate-level, medical-grade disinfectants EPA-registered as virucidal, bactericidal, tuberculocidal, and fungicidal.		Verify the facility thoroughly cleans and disinfects the entire operating room suite using EPA-registered, or internationally, regulatory-approved, disinfectant intermediate-level disinfectants to prevent cross-contamination and healthcare-associated infections. <u>Evaluating Compliance:</u> Review policies for alignment with recognized infection prevention and control guidelines (e.g., AORN, CDC, WHO), including: - Procedures to clean and disinfect all OR suite surfaces between procedures and during terminal cleaning - Specification to use EPA-registered, or internationally, regulatory-approved disinfectant, intermediate-level disinfectants Review cleaning logs to ensure cleaning is performed (first of day, in between patients, terminal) Interview staff regarding cleaning protocols (e.g., sequence, contact times) and PPE use Observe staff cleaning the operating room in between patients Inspect disinfectants for: - EPA or internationally equivalent registration number (e.g., "EPA Reg. No. XXXX-XX") - Claims of efficacy against healthcare-associated pathogens (e.g., TB, HBV, HIV) Confirm staff access to manufacturer's instructions for use (e.g., correct dilution, contact time).
7-F-3	A	B	C-M	C	There is a written policy for cleaning spills, especially spills that may contain blood-borne pathogens.		Verify the facility has safeguards in place to protect healthcare workers from exposure to bloodborne pathogens, through effective decontamination procedures for spills of blood or other potentially infectious materials (OPIM). <u>Evaluating Compliance:</u> Review policies for:

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							Procedure for decontaminating gross spills of blood or OPIM Directive to comply with OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030) Confirm inclusion of: - Only using appropriate EPA-registered tuberculocidal disinfectant or manually-diluted bleach solution (e.g., 1:10 dilution for blood spills) - Steps for containment, cleanup, and disposal of contaminated materials - Required personal protective equipment (e.g., gloves, gown, face protection) Interview staff to assess: - Awareness of the spill decontamination procedure - Knowledge of how to access and use PPE and cleanup supplies - Understanding of post-exposure protocols (e.g., reporting, prophylaxis) Review training records to ensure bloodborne pathogen training is documented.
7-F-4	A	B	C-M	C	All blood and body fluid spills are cleaned using medical-grade germicides that are virucidal, bactericidal, tuberculocidal, and fungicidal. A spill kit is available and readily accessible.		Verify safeguards are in place to protect workers from health hazards associated with blood and body fluid spills through the use of properly stocked, accessible spill kits and EPA-registered or internationally, regulatory-approved germicides . Staff must be trained to respond promptly and safely to spills. <u>Evaluating Compliance:</u> Review policies for blood/body fluid spill cleanup procedures that includes: - Use of an EPA-registered or internationally, regulatory-approved disinfectant germicide effective against viruses, bacteria, tuberculosis, and fungi - Step-by-step cleanup and disposal instructions - Required PPE (e.g., gloves, gown, face shield, mask) Interview staff regarding awareness of spill kit locations and protocols Observe staff cleaning spills (if applicable) Confirm spill kits are accessible in high-risk areas (e.g., procedure rooms, decontamination areas) and stocked with: - Sufficient absorbent materials (e.g., granules, pads) - PPE (gloves, gown, eye protection, mask) - Tools (e.g., scraper, brush, biohazard bags) - EPA-registered or internationally, regulatory-approved disinfectant (e.g., tuberculocidal solution).

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7-F-5	A	B	C-M	C	Facility policies and procedures have been developed for use by housekeeping personnel for cleaning floors, tables, walls, ceilings, counters, furniture, and fixtures of the operating suite.		Verify effective cleaning of the facility to minimize infection risks, whether housekeeping is performed internally or by a contracted vendor. Contracted services must be overseen through the facility's quality improvement program to ensure compliance with standards. <u>Evaluating Compliance:</u> Review policies for: Cleaning frequencies, methods, and agents for all areas (e.g., patient care zones, waiting areas, restrooms) Use of EPA-registered disinfectants appropriate for each surface or application Procedures for terminal cleaning Review cleaning logs to verify completion per policy Interview staff (internal or contract) for knowledge of cleaning protocols (in between patients, terminal) If cleaning services are contracted, review service oversight, including: Review the written contract to ensure it: Details specific areas to be cleaned, frequencies, and methods Requires the vendor to comply with all applicable standards (e.g., CDC, OSHA, QUAD A) Includes validation of staff competence and training Confirm the contract is integrated into the facility's quality improvement (QAPI) program, with processes for: Regular audits of cleaning effectiveness (e.g., visual inspection, ATP testing) Corrective actions for non-compliance.
7-F-6	A	B	C-M	C	Instrument handling and reprocessing areas are cleaned and maintained.		Verify the facility's instrument handling and reprocessing areas are consistently cleaned and maintained to minimize contamination risks and support effective sterilization/disinfection processes. <u>Evaluating Compliance:</u> Review cleaning logs to verify completion per policy (e.g., end of day, weekly deep cleaning) Interview staff regarding cross-contamination risks and cleaning protocols for reprocessing areas Inspect decontamination, preparation, and sterilization areas for evidence of: Organized surfaces and absence of visible soil, dust, or debris Segregation of clean and dirty zones.

SECTION 8: CLINICAL RECORDS

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section A: General Clinical Records							
8-A-5	A	B	C-M	C	Clinical records must be kept secure and confidential, consistent with national patient privacy regulations.		Verify patient health information (PHI) is secured against unauthorized access, damage, or theft through physical and electronic safeguards that comply with national patient health information privacy regulations. <u>Evaluating Compliance:</u> Review policies for: PHI access, storage, and disposal (e.g., shredding, digital wiping) procedures Breach response protocols (including patient notification) Interview staff regarding security protocols and mechanism for reporting suspected breaches Perform a security assessment, including: Hard copy medical records are: Stored in secure, locked locations (e.g., cabinets, rooms) Protected from unauthorized access, environmental hazards (e.g., fire, water), and theft Only authorized for approved personnel access (e.g., clinicians, designated staff) Electronic medical records utilize: Unique user authentication (e.g., passwords, PINs, biometrics) Role-based access controls limiting PHI to authorized staff Encryption for data at rest and in transit Audit trails tracking all access and modifications.
8-A-8	A	B	C-M	C	Clinical records for each patient must be accurate, legible, and promptly completed.		Verify clinical records are accurate, legible, complete, and promptly finalized to support safe, continuous patient care. Clinical records (hard copy or electronic) must meet legal, regulatory, and accreditation requirements. <u>Evaluating Compliance:</u> Review policies for: Timeliness requirements for documentation completion Authentication protocols (e.g., electronic signatures) Documentation requirements Interview staff regarding documentation standards and consequences of incomplete or late entries

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							Review clinical records to ensure they include, as applicable: - Patient identification (e.g., name, DOB, medical record number) - Significant medical history and physical exam results - Allergies and abnormal drug reactions - Pre-operative diagnostic studies (if performed) - Properly executed informed consent(s) - Operative findings and techniques, including pathology reports for removed tissues - Anesthesia administration records (if applicable) - Discharge diagnosis Confirm all entries are: - Accurate: reflect actual care provided and patient status - Legible: easily readable (handwritten or electronic) - Authenticated: signed and dated/timed by authorized author - Prompt: completed contemporaneously or as required by policy.
8-A-9	A	B	C-M	C	Clinical records must be retained the number of years as required by state and/or federal law; or a minimum of three (3) years to comply with the QUAD A three-year survey cycle.		Verify clinical records are retained for at least the minimum period required by QUAD A (3 years) and state/national law, whichever is longer. Records may be maintained in paper, electronic, or hybrid format, with secure destruction processes for paper records after conversion or retention expiration. Evaluating Compliance: - Review policies for mandatory retention ≥ 3 years (or longer state/national-mandated period) for active/inactive records - Confirm procedures for destroying paper-based records, that include: - Use of secure methods (e.g., shredding, incineration) to protect patient privacy - Authorization protocols (e.g., designated personnel, oversight) - Confirm procedures for EMR conversions ensure paper records are destroyed only after: - Successful data migration and validation - A defined, reasonable timeframe - Interview staff regarding retention requirements and destruction protocols, roles in destruction or conversion.
8-A-10	A	B	C-M	C	Clinical records are maintained and easily accessible by the accredited facility.		Verify clinical records are maintained in an organized system (electronic, paper, or hybrid) and are readily accessible to authorized personnel for patient care, continuity of care, and regulatory purposes. Evaluating Compliance: - Interview staff regarding record storage and retrieval processes during emergencies and transfers - Confirm record maintenance and organization:

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							Hard copy: records logically organized (e.g., by patient name/ID, date) and stored in a secure locations Electronic: system allows efficient searching and retrieval (e.g., by name, MRN, date of service) Confirm records are retrievable within a reasonable timeframe (e.g., minutes for active patients, hours for archived records) by requesting access to a clinical record randomly during survey activities.
Sub-section B: Pre-Operative Documentation							
8-B-1	A	B	C-M	C	Clinical records must contain patient identification.		Verify patient identity is accurately validated using multiple identifiers (e.g., full name, date of birth, unique ID) to prevent errors in care, treatment, and documentation. Photo identification alone is insufficient; corroborating details are required. <u>Evaluating Compliance:</u> Review policies for: Requirement of at least two (2) patient identifiers (e.g., name, DOB) before providing care Prohibition of reliance solely on photo ID or verbal confirmation by patient Interview staff regarding process for patient identification before procedures & medication administration Observe staff identify patients during provision of care (e.g., during patient intake) Review clinical records to ensure: Patient identity is clearly documented using first name, middle initial (if available), and last name Additional identifiers (e.g., DOB, MRN) are consistently included in records and on wristbands (if applicable).
8-B-2	A	B	C-M	C	A pre-operative surgical safety checklist must be used for each patient and noted in the patient record.		Verify a standardized preoperative safety checklist is consistently used, with each patient, to ensure critical safety issues are addressed before anesthesia induction, skin incision, and prior to the patient leaving the operating room. Use of safety checklists promotes teamwork, reduces errors, and enhances patient safety. <u>Evaluating Compliance:</u> Review checklist used by the facility (e.g., WHO, facility-specific) for all three (3) phases and key requirements: Before anesthesia induction (e.g., identity/procedure confirmation, site mark, anesthesia check, pulse oximetry, allergy/airway/blood loss

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							risks) Before skin incision (e.g., team introductions, timeout for procedure/site, antibiotic timing, critical event anticipation, sterility/equipment/counts confirmation) Before patient leaves the OR (e.g., procedure name, final counts, specimen labeling, recovery concerns) Interview staff regarding use of safety checklist, adherence to timeout protocols, and communication norms Observe checklist use in procedures for consistency and engagement Review clinical records to confirm completion of the checklist during each three (3) phases.
8-B-7	A	B	C-M	C	The pre-operative clinical record includes significant medical history and a physical examination covering the organs and systems commensurate with the procedure(s) are recorded on all patients and placed in the clinical record prior to the surgical procedure.		Verify that the H&P, when required, is completed and placed in the patient's clinical record before the pre-surgical assessment is performed. The pre-surgical assessment must incorporate the findings of the H&P. Both the H&P (if applicable) and the pre-surgical assessment must be in the patient's clinical record prior to the start of surgery. <u>Evaluating Compliance:</u> Review clinical records to confirm: The record contains both the H&P (if required) and the pre-surgical assessment. For patients scheduled for surgery during the on-site survey, both documents are present in the clinical record before the surgical procedure begins.
8-B-8	A	B	C-M	C	Upon admission, each patient must have a pre-operative assessment completed by a physician who will be performing the surgery or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and facility policy. The pre-surgical assessment must include documentation of any allergies to drugs and biologicals. This assessment must be placed in the patient's clinical record prior to the surgical procedure.		Verify that the pre-surgical assessment is completed and documented in the clinical record before the start of surgery, and that it includes documentation of allergies to drugs and biologicals—or a statement that the patient has no known allergies. <u>Evaluating Compliance:</u> Review clinical records to confirm: The operating physician, or another qualified practitioner acting within applicable state or national laws and standards of practice, has completed the pre-surgical assessment. The patient was examined prior to the commencement of surgery. Allergies (or “no known allergies”) are clearly documented.

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8-B-9	A	B	C-M	C	The pre-procedural operative assessment includes documentation regarding special needs such as physical impairments, disabilities, religious and/or ethnic concerns.		Verify each patient's unique needs (e.g., physical, cognitive, cultural, religious, communication) are identified, documented, and addressed prior to the procedure to deliver safe, personalized, and equitable care. Evaluating Compliance: Interview staff regarding assessing special needs and resource availability (e.g., interpreters, assistive devices) Observe patient interactions to ensure needs are respected and met Review clinical records for documentation of: Mobility limitations (e.g., need for assistance, bariatric equipment) Sensory impairments (e.g., hearing, vision deficits) Cognitive or behavioral conditions (e.g., dementia, anxiety) Language preferences or communication barriers (e.g., need for interpreter) Cultural or religious considerations (e.g., dietary restrictions, gender-specific preferences) Confirm staff address unique needs (e.g., use of interpreters, adaptive equipment, additional support staff).
8-B-10	A	B	C-M	C	The pre-operative clinical record includes documentation of blood pressure, pulse, respiration and temperature as taken prior to the operation.		Verify baseline vital signs(VS) (blood pressure, pulse, respirations, and temperature) are obtained and documented upon patient admission to establish a reference point for monitoring during and after the procedure. Evaluating Compliance: Review policies for requirement to document baseline VS at admission (prior to sedation or procedure) Observe staff during VS acquisition to confirm proper technique and timely documentation Review clinical records to ensure all four (4) VS are documented prior to sedation or start of procedure.
8-B-11	A	B	C-M	C	The pre-operative clinical record includes documentation of all pre-operative medications and intravenous fluids given to a patient. This record includes the patient's name, date, time, dose, and route of administration.		Verify all medications and intravenous fluids administered are accurately recorded to ensure patient safety, provide a legal record, and facilitate communication among the healthcare team. Evidence of Compliance: Observe staff administering preoperative medications and cross-check documentation for accuracy Review clinical records to confirm the documentation standard is met, including: name, date/time, dose, and route of administration.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
8-B-13	A	B	C-M	C	The pre-operative clinical record includes documentation of any allergies and abnormal drug reactions.		Verify patient medication allergies (and their specific reactions) or no known allergies are clearly documented in the clinical record to prevent adverse events and guide safe treatment decisions. <u>Evaluating Compliance:</u> Interview staff regarding process for obtaining/documenting allergies and actions taken when identified Observe staff for allergy verification during patient intake Review clinical records to verify allergies are prominently documented (e.g., front of chart, electronic health record alert) Confirm entries include allergen, reaction details, and date of last occurrence/validation (if known).
8-B-14	A	B	C-M	C	The pre-operative clinical record includes documentation of current medications.		Verify all current patient medications (including prescriptions, over-the-counter drugs, supplements, and herbals) are accurately documented in the clinical record to support safe medication management and avoid adverse interactions. <u>Evaluating Compliance:</u> Interview staff regarding: Procedures for obtaining and updating medication histories Understanding of the importance of including non-prescription products. Observe staff for medication history collection during patient intake Review clinical records to verify a complete and current medication list with: Drug name, dose, frequency, and route for each medication Prescription, OTC, and supplement/herbal products Documentation source Check for reconciliation at admission, transfer, and discharge (if applicable).
8-B-15	A	B	C-M	C	The pre-operative clinical record includes documentation of medical history.		Verify the patient's complete and accurate medical history is documented in the clinical record to inform safe decision-making, assess risks, and guide appropriate care throughout the procedural experience. <u>Evaluating Compliance:</u> Interview staff regarding Understanding of the required elements of a medical history Processes for obtaining, documenting, and updating the history Observe history-taking during patient intake (if applicable) Review clinical records to ensure the medical history includes (as

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							applicable to the procedure): - Chronic conditions - Previous surgeries and hospitalizations. - Family history - Social history - Obstetric/gynecologic history Confirm history is patient-specific, current, and signed/authenticated by the authorized provider.
8-B-17	A	B	C-M	C	The pre-operative clinical record includes documentation of any previous operations.		Verify the patient's history of previous operations is accurately documented in the clinical record to inform care planning and support safe delivery of services. <u>Evaluating Compliance:</u> Observe history-taking during patient intake for thoroughness. Review clinical records to ensure the record includes a list of previous surgeries Confirm documentation is current and from appropriate sources.
8-B-18	A	B	C-M	C	The pre-operative clinical record includes documentation of perioperative bleeding risk, including medical conditions and anticoagulant medication taken up to the day of the operation.		Verify any factors that may increase a patient's risk of perioperative bleeding are thoroughly documented in the clinical record. This allows the care team to take appropriate precautions to minimize bleeding risks and respond effectively should bleeding occur. <u>Evaluating Compliance:</u> Interview staff regarding: - Understanding of factors that contribute to bleeding risk - Procedures for assessing, documenting, and communicating bleeding risks (e.g., safety checklist) - Processes for managing patients with identified bleeding risks Observe staff updating bleeding risk on the surgery checklist (if possible and applicable) Review clinical records to verify documentation includes: - Use of anticoagulants, antiplatelets, or other medications that affect coagulation - Known bleeding or clotting disorders - Relevant medical history such as liver disease, renal impairment, or hematologic conditions - Family history of bleeding disorders - Previous surgical or dental bleeding complications (as applicable) Confirm that the plan of care addresses any identified bleeding risks (if applicable).

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8-B-19	A	B	C-M	C	A written pregnancy testing policy must be in place that requires discussion and documentation of the issue with each patient, as appropriate.		Verify the pregnancy status (of patients of childbearing potential) is appropriately discussed, documented, and considered in procedural planning to promote patient safety and informed decision-making in accordance with the facility policy. Evaluating Compliance: Review policies for directive to assess/document pregnancy status (as applicable), including: Testing criteria (e.g., all females of childbearing age unless exempted by hysterectomy, menopause, etc.) Methods for discussion and testing (e.g., patient-reported history, point-of-care testing) Procedures for documenting patient discussion, declinations, or test results Interview staff regarding when/how to test for pregnancy status and process for positive results Review clinical records for: Documentation of pregnancy status discussion, testing, and results Evidence of informed decision-making for positive results (e.g., procedure timing, modifications).
8-B-20	A	B	C-M	C	The pre-operative clinical record includes evidence that treating physicians or consultants are contacted in cases when warranted by the history and physical examination.		Verify consultations with treating physicians or specialists are initiated and documented when the history and physical reveals conditions that could impact procedural safety. Evaluating Compliance: Interview staff regarding: Criteria for initiating consultations Procedures for communicating and documenting consultant input Processes for managing time-sensitive consultations Review clinical records to verify documentation includes: Identification of conditions warranting consultation Evidence of communication with relevant physicians or specialists Recommendations from consultants incorporated into the plan of care Confirm consultations occur prior to the procedure (when possible) and timeliness of clearance abides by the facility policy.
8-B-22	A	B	C-M	C	The pre-operative clinical record includes pre-operative diagnostic studies and laboratory procedures (entered before surgery), if performed.		Verify that if pre-operative diagnostic studies were performed, they must be included in the medical record prior to the start of surgery. Evaluating Compliance: Review clinical record to confirm: Presence of any pre-operative ancillary testing (e.g., labs,

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							diagnostic imaging).
8-B-23		B	C-M	C	For patients receiving general anesthesia or surgical procedures scheduled for 60 minutes or longer or for patients with a history of venous thromboembolism (VTE), the pre-operative clinical record includes a written screening protocol for VTE risk. This protocol and assessment tool are to be placed in the facility manual for reference.		Verify all patients undergoing general anesthesia, procedures lasting 60 minutes (or longer), or those with a history of venous thromboembolism (VTE), receive a standardized VTE risk assessment. Use evidence-based tools like the Caprini score to identify risk levels and implement appropriate preventive measures to reduce VTE occurrence. <u>Evaluating Compliance</u> Review policies for: Approval of a validated VTE risk assessment tool (e.g., Caprini score) Requirement of VTE risk assessment for eligible patients outlining prophylactic interventions (as applicable) Interview staff regarding VTE risk factors, assessment tools, and intervention protocols Observe care to ensure care includes VTE prevention protocols (if possible and applicable) Review clinical records for: Documentation of VTE risk assessment prior to procedure For high-risk patients, cross-check that interventions (e.g., pharmacological prophylaxis, mechanical compression devices, early mobilization) are implemented and documented.
8-B-24		B	C-M	C	The surgeon/proceduralist and the licensed or qualified anesthesia professional concur on the appropriateness of the procedures performed at the facility based on the medical status of the patient, age and physiological appropriateness of the patient, and qualifications of the providers and the facility resources. This concurrence must be documented in the clinical record.		Verify surgical team communication exists to ensure procedures are appropriate for the patient's medical status, age, and physiological needs. The surgeon or proceduralist and anesthesia professional must concur on this appropriateness, and their agreement must be documented per facility policy. This requirement does not apply if the surgeon or proceduralist also administers anesthesia or if an RN administers sedation under their direct orders. <u>Evaluating Compliance</u> Review policies for process for how/where concurrence is documented (e.g., pre-op checklist, time-out form) Interview staff regarding understanding of concurrence/documentation process and exemptions Review clinical records for documentation of concurrence (e.g., check box, initialed entry) for all applicable cases.

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8-B-27	A	B	C-M	C	A physician is responsible for determining the medical status of the patient and must examine the patient immediately before procedures and update the H & P.		Verify any changes in the patient's medical status (since the preoperative history and physical) are identified and documented immediately prior to the procedure. This focused assessment updates the H&P and evaluates procedure and anesthesia risks based on the patient's current condition, the planned procedure, and the anesthesia type. <u>Evaluating Compliance</u> Interview staff regarding: How to identify and document changes in patient status Review clinical records for: Preoperative assessment conducted immediately before the procedure by an appropriate staff member Evaluation of risks related to the procedure and anesthesia Confirmation the updated assessment addresses any changes in the patient's condition since original H&P
8-B-29	A	B	C-M	C	An anesthesia history and physical and risk assessment (e.g. physical status anesthesia classification) are recorded in the medical/dental records.		Ensure the anesthesia history of pediatric patients is assessed prior to any procedure, confirming the patient's readiness for the planned anesthesia and addressing any special considerations for pediatric care. <u>Evaluating Compliance</u> Interview staff regarding process to ensure pediatric anesthesia assessment is performed before proceeding to the procedure area Review clinical records for: Documentation of anesthesia history Plan of care specific to minimizing risk of known anesthesia reactions (when applicable).
8-B-32	A	B	C-M	C	The facility must implement a policy related to patient health needs that are noted during the health assessment conducted preoperatively. The policy must include providing and documenting relevant patient education related to identified areas of need as applicable, such as: 1. Smoking cessation; 2. Importance of good nutrition; 3. Importance of exercise; and 4. Substance abuse resources in the medical record.		Verify the facility implements a comprehensive policy addressing patient health needs identified during preoperative assessments. This policy must include provisions for providing and documenting patient education related to specific health needs, including smoking cessation, nutrition, exercise, and substance abuse resources. Education must be tailored to the patient's identified risks and documented in the medical record to support continuity of care and promote positive health outcomes. <u>Evaluating Compliance</u> Review policies for requirement of providing/documenting patient education for health needs identified Interview staff regarding procedures for providing patient education &

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							resources for education material Review clinical records for evidence of: Specific health needs identified at preoperative assessment Appropriate education provided (with referrals when applicable).
Sub-section C: Informed Consent							
8-C-1	A	B	C-M	C	Properly executed informed consent forms are always obtained, from the patient or, if applicable, the patient's representative, which includes: · A description of the proposed surgery, including the anesthesia to be used; · The indications for the proposed surgery; · Risks and benefits; · Treatment alternatives; · The surgeon/proceduralist by name to perform surgery; · Whether physicians other than the operating practitioner will be performing important tasks related to the surgery; and · Whether, as permitted by State law, qualified medical practitioners who are not physicians will perform important parts of the surgery or administer the anesthesia, and if so, the types of tasks each type of practitioner will carry out.		Verify properly executed informed consent is obtained from the patient (or representative) prior to any surgical or invasive procedure. The consent process must be thorough, transparent, and documented, covering all critical elements to ensure the patient (or representative) fully understands the procedure, its risks, benefits, alternatives, and the roles of all involved practitioners. Evaluating Compliance: Review policies regarding informed consent and directives to ensure: All required elements are addressed when attaining an informed consent Written consent is attained before the surgery/procedure Only authorized staff may obtain consent Patients lacking capacity (e.g., children, cognitive impairment) require consent from a legal representative Interview staff and practitioners regarding: Process for attaining consent (who may attain consent, who may witness signatures) Process for when patients lack capacity Review clinical records for evidence of properly executed informed consent, that includes: Description of the proposed surgery and anesthesia Indications for the surgery Risks and benefits Treatment alternatives Name of the surgeon/proceduralist Disclosure if other physicians will perform important tasks Disclosure if non-physician practitioners will perform important tasks & their roles (as permitted by law) Signature by the patient (or representative) before sedation or commencement of the procedure.
8-C-3		B	C-M	C	The written informed consent provides consent for the administration of anesthesia or sedatives under the direction of the surgeon, anesthesiologist, or CRNA.		Verify a properly executed informed consent for anesthesia or sedation is obtained and documented prior to the procedure. The consent process must involve the anesthesia professional when anesthesia care is discussed, whether through a separate consent form or integrated into the surgical consent.

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							<u>Evaluating Compliance:</u> Interview staff regarding informed consent requirements for anesthesia or sedation Observe staff attaining and documenting consent for sedation or anesthesia Review clinical records for evidence of properly executed anesthesia/sedation preoperatively (when applicable) If the anesthesia consent is integrated into the surgical consent, ensure the anesthesia professional participated in the consent process and discussed the anesthesia care plan with the patient (or representative).
8-C-4	A	B	C-M	C	The patient signs a consent form if research protocols, videography, or photography are to take place.		Verify patients (or representatives) retain the right to withdraw consent, at any time, for research protocols, videography, or photography used for marketing purposes. This standard does not apply to audiovisual media used solely for medical documentation, such as endoscopic or colonoscopic procedures. <u>Evaluating Compliance:</u> Review policies regarding patient consent for marketing-related videography or photography to ensure: Policies explicitly state the right to withdraw consent at any time Policies distinguish between marketing use and medical documentation use Interview staff regarding consent requirements for media used for marketing and consent withdrawal process Interview patients regarding giving consent and withdrawal processes Review clinical records for evidence of consent for marketing-related audiovisual activities, that includes: Documentation of processes to withdraw consent Verification of consent for use in marketing-related media (when applicable).
Sub-section E: Laboratory, Pathology, X-Ray, Consultation, Treating Physician Reports, etc.							
8-E-1	A	B	C-M	C	Reports of laboratory, pathology, X-ray, consultation, treating physician, and any other diagnostic tests are maintained in the clinical record and are accessible for review prior to the procedure.		Verify all relevant reports (e.g., diagnostic results, consultations, and pre-operative assessments) are accessible in the medical record prior to the procedure. Reports (either hard copy or electronic) must be available for review by the procedural team to support safe patient care. <u>Evaluating Compliance</u> Review policies for directive that all reports to be available in the

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							clinical record before the procedure Review clinical records to confirm that all required reports are present/accessible prior to the procedure and have been reviewed.
8-E-5	A	B	C-M	C	The name of the healthcare provider appears on the reports.		Verify the name of the healthcare provider responsible for generating, interpreting, or reviewing reports is clearly documented on all clinical reports. This includes diagnostic, laboratory, consultation, and procedural reports to ensure accountability, traceability, and continuity of care. Evaluating Compliance Review policies for directive for healthcare provider's full name and credentials to appear on clinical reports Review clinical records to confirm all reports include the full name and credentials of the healthcare provider responsible for generating content.
8-E-6	A	B	C-M	C	Outside clinical laboratory procedures must be performed by a licensed and accredited facility.		Verify outside clinical laboratories used by the facility are properly licensed, accredited, and comply with all applicable regulations to guarantee safe and accurate laboratory procedures. If laboratories are located in another country, facility policy must explicitly state whether results from these laboratories will be accepted and under what conditions. Evaluating Compliance Review policies for use of outside clinical laboratories to confirm: Domestic Labs: Evidence of licensure, accreditation, and CLIA certification International Labs: Whether results will be accepted and verification requirements/special considerations Review documentation for all outside laboratories to validate requirements are met Interview staff regarding requirements for using outside laboratories and credentialing standards.
8-E-9	A	B	C-M	C	The name of the pathologist must be on all pathology reports.		Verify the name of the licensed physician responsible for the pathological review of surgical specimens is clearly documented on all pathology reports. Evaluating Compliance: Review policies for directive that the pathologist name and credentials must appear on all pathology reports Review clinical records to confirm all pathology reports include the full name and credentials of the pathologist (when applicable).

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8-E-10	A	B	C-M	C	All laboratory results must be reviewed and acknowledged by the ordering health care provider.		Verify all laboratory results are reviewed and acknowledged by the ordering healthcare provider. This process confirms that results are assessed, acted upon if necessary, and integrated into the patient's care plan in a timely manner. <u>Evaluating Compliance:</u> Review policies for: Process for reviewing laboratory results, including identification of abnormal values and required actions Directive that all laboratory results must be reviewed by the ordering healthcare provider The timeframe for review and the method of acknowledgment Interview staff regarding: Laboratory review and acknowledgement process Documentation requirements Review clinical records to verify: All laboratory results are reviewed and acknowledged by ordering provider Acknowledgments include the provider's name, credentials, and date/time of review Acknowledgements in electronic health records are electronically authenticated.
8-E-11	A	B	C-M	C	All other reports, such as pathology reports and medical clearance reports, must be reviewed and acknowledged by the ordering healthcare provider.		Verify all reports, such as pathology and medical clearance reports, are reviewed and acknowledged by the ordering healthcare provider, who may be an internal or external provider (e.g., referring physician, consultant). This process ensures that critical diagnostic and clinical information is assessed, integrated into the patient's care plan, and acted upon when necessary. <u>Evaluating Compliance:</u> Review policies for: Directive that all medical reports must be reviewed and acknowledged by the ordering provider Procedures for both internal and external ordering providers The timeframe for review and the method of acknowledgment Documentation standards, including electronic authentication (reviewer's name, title, date/time of review) Interview staff regarding: Report review and acknowledgement process How to facilitate acknowledgment from external providers and document it appropriately Review clinical records to verify: All relevant reports are present and reviewed by the ordering

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							healthcare provider Documentation of report transmission and acknowledgment from external providers Hard copy records: review is documented with initials, date, and time Electronic records: review is electronically authenticated with the required elements.
8-E-12	A	B	C-M	C	If tests/studies are done in the facility, the laboratory meets applicable licensure, standards, and state/provincial/national laws and regulations.		Verify all laboratory tests and studies performed within the facility comply with applicable licensure requirements, recognized standards, and state/provincial/national laws and regulations. This includes adherence to clinical laboratory standards, safety protocols, and quality assurance measures to guarantee accurate, reliable, and safe testing processes. <u>Evaluating Compliance:</u> Review policies for: Directive requiring compliance with applicable licensure, standards, and regulations for in-house lab testing References to specific standards (e.g., relevant national or provincial requirements) Procedures for regular audits, competency assessments, and quality control measures Review documents for evidence that: Lab license/certification/accreditation documents are compliant with applicable requirements Quality control records, proficiency testing results, and audit reports adherence to standards Laboratory staff credentials and training records are up-to-date and meet regulatory requirements Interview laboratory staff regarding knowledge of applicable standards, regulations, and facility policies Interview laboratory managers for knowledge of reporting requirements for incidents of non-compliance Observe staff performing testing protocols, safety measures, and quality assurance procedures .
8-E-13	A	B	C-M	C	All surgical specimens sent out for pathology must be documented in a pathology specimen log, which minimally includes the date, patient's name, number and type of specimen (biopsy, swab, fluid, etc.), and physician's name.		Verify all surgical specimens sent for pathology are accurately identified, tracked, and documented to prevent errors, maintain chain of custody, and ensure patient safety. The facility must implement a robust tracking system that captures all required elements from specimen collection to pathology processing. <u>Evaluating Compliance</u>

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							Review policies for: - Procedures for the complete specimen handling process (identification, labeling, transport, and tracking) - Procedures for resolving discrepancies or lost specimens - Security of the log Review specimen log to verify it contains the required elements: - Patient name and unique identifier (e.g., medical record number) - Specimen type and source - Date and time of collection - Name of the healthcare professional who collected the specimen - Name of the individual transporting the specimen - Date and time of specimen receipt by pathology Confirm the log demonstrates continuity and accountability throughout the entire process Interview staff regarding knowledge of: - Specimen identification and tracking procedures - How to handle discrepancies (e.g., mismatched labels, lost specimens) Observe staff involved in specimen handling for proper labeling and documentation practices.
Sub-section F: Anesthesia Care Plan							
8-F-12	A				The anesthesia care plan is based on allergy history.		Verify the development of a safe, individualized anesthesia care plan that prevents exposures to patient reported allergens. <u>Evaluating Compliance</u> Review policies for: - Directive for an individualized anesthesia care plan for each patient - Specifying required elements of the plan (e.g., patient history, physical status, anesthesia type, risks) - Documentation formats (e.g., checklists, narratives, or electronic templates) Interview provider to assess their understanding of the care plan development process Review clinical records to confirm the pre-anesthesia assessment and anesthesia care plan include the required elements: - Patient's medical history and physical status (including assessment of allergens and reactions) - Type of anesthesia planned - Monitoring plan - Contingency plans for potential complications Verify the plan is individualized to the patient's needs and is signed/authenticated by the provider.

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8-F-13		B	C-M	C	An anesthesia care plan is present that is based on, at a minimum, the following: · The patient's medical history; · The patient's prior anesthetic experiences; · Drug therapies; · A medical examination of the patient and assessment of any conditions that might affect the patient's pre-operative risk; · A review of the medical tests and consultations · The determination of pre-operative medications needed for anesthesia; · Providing pre-operative instructions; and, · Allergy history		Verify the development of a safe, individualized anesthesia care plan based on a comprehensive pre-anesthesia assessment. The plan must be documented using facility-defined methods and include all required elements to guide patient-specific anesthesia delivery. <u>Evaluating Compliance:</u> Review policies for: Directive for an individualized anesthesia care plan Required elements of the plan (e.g., patient history, physical status, anesthesia type, risks) Acceptable documentation formats (e.g., checklists, narratives, electronic templates) Interview anesthesia professional to assess understanding of: Care plan development process How the plan is tailored to each patient's unique needs Review clinical records to confirm the pre-anesthesia assessment/anesthesia care plan include: Patient's medical history and physical status (including allergy history) Previous anesthetic experiences Current drug therapies Review of medical tests and consultations Type of anesthesia/airway management planned Pre-operative medications needed for anesthesia Providing pre-operative instructions / assessing understanding Verify the plan addresses the patient's needs and is signed/authenticated by the anesthesia professional.
Sub-section G: Intra-Operative Documentation							
8-G-1	A	B	C-M	C	A "Time Out" protocol is in place, practiced, and documented in the clinical record prior to every operation. This protocol must include: · A pre-operative verification process including clinical records, imaging studies, surgical fire risk, and any implants identified, and be reviewed by the operating room team. Missing information or discrepancies must be addressed in the clinical record at this time. · Marking the operative site: Surgical procedures calling for right/left distinction; multiple structures (breasts, eyes, fingers, toes, etc.) must be marked while the patient is awake and aware, if possible. The person performing the		Verify a standardized time-out is conducted immediately before starting any invasive procedure or making the incision to verify the correct patient, procedure, and site. The entire surgical team must actively participate, and the process must be documented. The time-out is distinct from pre-operative checklists and focuses solely on final verification to prevent wrong-site, wrong-procedure, and wrong-patient events. <u>Evaluating Compliance:</u> Review policies for: Directive requiring a time-out immediately before all invasive procedures Required elements of the time-out, including patient identity, procedure, site, and critical safety steps

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					surgery should do the site marking. The site must be marked so that the mark will be visible after the patient has been prepped and draped. A procedure must be in place for patients who refuse site marking. · Immediately before starting the surgical procedure, conduct a final verification by at least two (2) members of the surgical team confirming the correct patient, surgery, site marking(s) and, as applicable, implants and special equipment or requirements. As a “fail-safe” measure, the surgical procedure is not started until any and all questions or concerns are resolved. · Procedures performed in non–operating room settings must include site marking for any procedures involving laterality, or multiple structures. Note: Applicable to Class A effective 1/26/26		Mandated participation of the surgical team Documentation standards Procedures for addressing discrepancies Interview staff regarding the time-out process, roles/active participation, handling discrepancies Observe staff conducting a time-out Review clinical records to confirm time-out documentation includes: Patient identification Procedure and site verification Names of participating team members Date/time performed Discrepancies/corrective actions (when found).
Sub-section H: Intra-Operative Anesthetic Monitoring and Documentation							
8-H-1		B	C-M	C	A qualified anesthesia professional shall be present in the OR/procedure room throughout the conduct of all general anesthetics, regional anesthetics, and monitored anesthesia care.		Verify that qualified anesthesia professional is physically present in the procedure room and continuously monitors the patient throughout all general anesthetics, regional anesthetics, and monitored anesthesia care. This uninterrupted presence is essential to respond immediately to changes in patient status and maintain safety. Evaluating Compliance: Review policies for: Directive that qualified anesthesia professionals are continuously present during anesthesia administration Definition of "qualified anesthesia professional" according to state regulations & professional standards Interview anesthesia staff regarding continuous presence requirements Observe anesthesia administration to assess continuous presence Review clinical records (anesthesia records) for evidence of: Uninterrupted monitoring (vital signs, oxygenation levels, ventilation) Medication administration Interventions at appropriate intervals.
8-H-2		B	C-M	C	Clinical records must contain evidence of circulation monitored by continuous EKG during procedures. Note: This standard does not apply if only topical and/or		Verify continuous electrocardiogram (EKG) monitoring is maintained and interpreted for every patient under moderate sedation, deep sedation, and general anesthesia, from sedation/anesthesia initiation until the patient is prepared to leave the anesthetizing location. This

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				local anesthetic is used without the use of an oral premedication.		monitoring is essential for assessing circulatory function and detecting cardiac abnormalities during anesthesia care. <u>Evaluating Compliance:</u> Review policies for: Directive for continuous EKG monitoring (from initiation of anesthesia until leaving anesthetizing location) EKG interpretation and documentation requirements Interview anesthesia staff regarding EKG monitoring/interpretation/documentation protocols Observe practice to confirm continuous EKG monitoring and appropriate interpretation Review clinical records (anesthesia records) for evidence of: Continuous EKG monitoring until preparing to leave the anesthetizing location Interpretation of the EKG tracing (noting abnormalities and interventions).
8-H-3	B	C-M	C	Clinical records must contain evidence of circulation monitored by blood pressure documented at least every five (5) minutes. Note: This standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.		Verify continuous monitoring and evaluation of circulatory function for all patients under moderate sedation, deep sedation, and general anesthesia to maintain hemodynamic stability. This includes continuous heart rate and cardiovascular status monitoring, with documented blood pressure, heart rate, and respiration readings at least every five (5) minutes throughout anesthesia administration. <u>Evaluating Compliance:</u> Review policies for: Directive for continuous circulatory monitoring (initiation of anesthesia until leaving anesthetizing location) Requirement for documentation of BP, HR, and respiration ≥ every five (5) minutes Protocols for continuous cardiovascular status assessment and intervention Interview anesthesia staff regarding circulatory monitoring/assessment/documentation requirements Observe practice to confirm continuous circulatory monitoring and appropriate interpretation Review clinical records (anesthesia records) for evidence of: Continuous circulatory monitoring until preparing to leave the anesthetizing location Blood pressure is recorded ≥ every five (5) minutes Interpretation of cardiovascular status assessment (noting abnormalities and interventions).

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8-H-4		B	C-M	C	Clinical records must contain evidence of circulation monitored by heart rate documented at least every five (5) minutes. Note: This standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.		Verify continuous monitoring and evaluation of circulatory function for all patients under moderate sedation, deep sedation, and general anesthesia to maintain hemodynamic stability. This includes continuous heart rate and cardiovascular status monitoring, with documented blood pressure, heart rate, and respiration readings at least every five (5) minutes throughout anesthesia administration. <u>Evaluating Compliance:</u> Review policies for: Directive for continuous circulatory monitoring (initiation of anesthesia until leaving anesthetizing location) Requirement for documentation of BP, HR, and respiration ≥ every five (5) minutes Protocols for continuous cardiovascular status assessment and intervention Interview anesthesia staff regarding circulatory monitoring/assessment/documentation requirements Observe practice to confirm continuous circulatory monitoring and appropriate interpretation Review clinical records (anesthesia records) for evidence of: Continuous circulatory monitoring until preparing to leave the anesthetizing location Heart rate is recorded ≥ every five (5) minutes Interpretation of cardiovascular status assessment (noting abnormalities and interventions).
8-H-5	A	B	C-M	C	The clinical record must contain evidence of oxygenation and circulation monitoring by continuous pulse oximetry. When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm shall be audible to the care team. Note: This standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.		Verify adequate oxygen concentration in the blood is maintained during all anesthetics through continuous monitoring via clinical observation and pulse oximetry. Pulse oximetry must be employed for all anesthetics except topical and local anesthesia without oral premedication. When used, the pulse oximeter's variable pitch pulse tone and low threshold alarm must be audible to the care team. <u>Evaluating Compliance:</u> Review policies for: Requirement for continuous oxygenation monitoring via pulse oximetry for all applicable anesthetics Mandate that the pulse oximeter's audible tone and low threshold alarm is active/audible to the care team Definition of exceptions (e.g., topical/local anesthesia without oral premedication) Interview staff regarding monitoring requirements and alarm management

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							Observe practice to ensure pulse oximetry is applied and alarms are audible Confirm functional pulse oximeters with audible variable pitch tones & low threshold alarms Review clinical records (anesthesia records) for evidence of: - Continuous pulse oximetry monitoring during delivery of anesthesia and post-anesthesia care - Responses to any desaturation events.
8-H-9			C-M	C	Clinical records must contain evidence of temperature monitoring when clinically significant changes in body temperature are expected.		Verify appropriate body temperature is maintained during all anesthetics (except those procedures using local or minimal sedation or lasting less than 30 minutes). Temperature must be monitored when clinically significant changes are intended, anticipated, or suspected. The facility must use active measures to maintain normothermia. When malignant hyperthermia (MH) triggering agents are present, monitor temperature and be prepared to recognize and manage MH immediately. <u>Evaluating Compliance:</u> Review policies for: - Definition of when temperature monitoring is required - Requirement of active warming/cooling measures to maintain normothermia - Protocols for temperature monitoring and MH response (if triggering agents are present) Interview staff regarding: - Protocols for temperature monitoring and active management - MH signs/symptoms and emergency response (if triggering agents are present) Observe practice to confirm adherence to temperature monitoring and management protocols Review clinical records (anesthesia records) for evidence of: - Temperature monitoring (when required) - Active temperature management and interventions.
8-H-11		B	C-M	C	Patient monitoring during anesthesia consists of end tidal carbon dioxide (ETCO₂) sampling used on all moderate sedation, deep sedation or general anesthesia cases. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure, or equipment.		Verify adequate ventilation is continuously monitored during moderate sedation, deep sedation, and general anesthesia through clinical observation and confirmation of expired carbon dioxide. Verify proper airway device placement using auscultation, chest excursion, and expired carbon dioxide detection. Use end-tidal carbon dioxide (ETCO₂) monitoring unless invalidated by patient, procedural, or equipment factors, with rationale documented

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							Note: Quantitative (numerical) ETCO₂ values are only accurate with advanced airways; nasal cannulas or similar devices yield inaccurate readings and qualitative symbols (+) are appropriate for documentation. <u>Evaluating Compliance:</u> Review policies for: Directive for continuous ventilation monitoring via observation & ETCO₂ during moderate/deep sedation and general anesthesia Defined methods to verify airway device placement (e.g., auscultation, chest excursion, ETCO₂) Specification of when ETCO₂ monitoring may be invalidated (and requirement to document rationale) ETCO₂ numerical values are only documented when an advanced airway is used Interview staff regarding ETCO₂ use, and documentation standards Observe practice to ensure proper ventilation monitoring and device verification Review clinical records (anesthesia records) for evidence of: Continuous ventilation monitoring and ETCO₂ use (when applicable) Airway device verification (e.g., auscultation, ETCO₂ confirmation) Documentation of rationale if ETCO₂ monitoring is not used Confirm ETCO₂ numerical values are only recorded with advanced airways; use qualitative indicators (e.g., "+" for presence) otherwise.
8-H-12				C	When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas and documented in the clinical record. Continual end-tidal carbon dioxide (ETCO₂) analysis, in use from the time of endotracheal tube/laryngeal mask placement until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry, or mass spectroscopy. When capnography or capnometry is utilized, the end tidal carbon dioxide alarm shall be audible to the Anesthesiologist or the anesthesia professional.		Verify adequate ventilation is continuously monitored and maintained during general anesthesia through clinical observation, mechanical monitoring, and functional alarm systems to prevent hypoventilation or respiratory compromise. <u>Evaluating Compliance:</u> Review policies for: Directive for continuous ventilation monitoring during general anesthesia Defined methods for monitoring (e.g., auscultation, capnography, spirometry) Mandate for use of functional alarm systems for ventilation equipment Interview anesthesia staff regarding ventilation monitoring protocols and alarm management Observe practice to ensure staff respond appropriately to ventilation changes or alarms

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							Review clinical records (anesthesia records) for evidence of: - Continuous ventilation monitoring (e.g., ETCO₂, respiratory rate, tidal volume) - Responses to any ventilation alarms or abnormalities - Confirm ventilation monitors and alarms are functional and audible.
8-H-13				C	If an anesthesia machine is used during general anesthesia, the anesthesia machine must have an alarm for low O ₂ concentration.		Verify the use of critical safety alarms for low oxygen concentration that alerts the anesthesia professionals to a potentially fatal equipment malfunction or system failure during general anesthesia (GA) administration. Evaluating Compliance: Review policies for mandatory use of alarm systems to detect low oxygen concentration during GA Interview anesthesia staff regarding pre-procedure equipment safety checks & alarm management Confirm alarm is functional by having anesthesia staff demonstrate a safety check .
8-H-14		B	C-M	C	Patient monitoring during anesthesia will consist of assessing the patient's color. To facilitate this assessment, adequate illumination and exposure of the patient are necessary.		Verify adequate ventilation is continuously monitored and maintained during sedation and general anesthesia through clinical observation, mechanical monitoring, and functional alarm systems to prevent hypoventilation or respiratory compromise. Evaluating Compliance: Review policies for: - Requirement for continuous ventilation monitoring during sedation and general anesthesia cases - Defining methods of monitoring (e.g., observation, auscultation, capnography, spirometry) - Mandate for use of functional alarm systems for ventilation equipment Interview staff regarding protocols to monitor for adequate ventilation (e.g., mucous membranes color) Observe practice to ensure staff respond appropriately to alarms or patient color changes Review clinical records (anesthesia records) for evidence of: - Continuous ventilation monitoring (e.g., ETCO₂, respiratory rate, mucous membrane color) - Responses to any abnormalities.
8-H-15		B	C-M	C	An anesthesia record is maintained in which all medications given to a patient are recorded, including date, time, amount, and route of administration.		Verify the intra-procedures anesthesia record accurately and comprehensively documents all medications administered during the procedure, including name, dose, route, time, and the individual who

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							administered them. This documentation is critical for patient safety, continuity of care, and legal accountability. <u>Evaluating Compliance:</u> Review policies for: Requirement for real-time documentation of all medications administered during anesthesia Documentation standards (drug name, dose, route, time, and administering personnel) Prohibition for late entries or undocumented medications Interview staff regarding medication documentation protocols Observe practice to confirm medications are documented immediately Review clinical records (anesthesia records) for evidence of: All medications given during the procedure, with all entries including: Drug name Exact dose Route of administration Time of administration Identity of administering staff.
8-H-16		B	C-M	C	An anesthesia record is maintained in which all intravenous fluids given intra-operatively are recorded.		Verify the intra-procedure anesthesia record accurately documents all intravenous fluids administered during the procedure, including type, volume, rate, and duration. This documentation is essential for tracking fluid balance, guiding clinical decisions, and patient safety. <u>Evaluating Compliance:</u> Review policies for: Requirement for real-time documentation of all intravenous fluids administered during anesthesia Documentation standard (fluid type, volume, infusion rate, start/stop times, administering staff) Interview staff regarding fluid documentation protocols Observe practice to confirm fluids are documented immediately during administration Review clinical records (anesthesia records) for evidence of: All intravenous fluids given during the procedure, with all entries including: Fluid type Total volume administered Infusion rate Start and stop times Identity of administering staff

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							Confirm fluid balance calculations (if applicable).
8-H-17		B	C-M	C	An anesthesia record is maintained in which the duration of the procedure is recorded.		Verify the intra-procedure anesthesia record accurately documents the duration of the procedure, including start and end times of anesthesia and surgery. This documentation is essential for tracking procedural timelines, billing accuracy, and clinical outcomes. Evaluating Compliance Interview anesthesia staff regarding protocols for documenting surgical and anesthesia times Review clinical records for evidence of: Anesthesia start time/end time Surgical start time/end time Total procedure duration Cross-check anesthesia and nursing records for consistency between times recorded.
8-H-18		B	C-M	C	An anesthesia record is maintained for each case in which IV or general anesthesia is used.		Verify a complete anesthesia record is maintained for every case involving intravenous (IV) sedation or general anesthesia (GA). This record must accurately document all aspects of anesthesia care to ensure patient safety, support clinical decision-making, and meet legal and regulatory requirements. Evaluating Compliance: Review policies for: Requirement to document the provision of anesthesia services (with IV sedation or GA) Documentation requirements (based on recognized anesthesia standards) Interview anesthesia staff regarding protocols for documenting anesthesia services Observe practice to ensure an accurate anesthesia record is maintained Review clinical records (anesthesia record) for all IV sedation and GA cases, including the following: Patient identification Time-based vital signs Continuous circulatory and ventilation monitoring All medications and IV fluids administered Airway management details Adverse events and interventions Start and end times of anesthesia Signature of anesthesia provider.

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8-H-19		B	C-M	C	Ventilation is noted by: Clinical signs are evaluated by continual observation during regional/sedation analgesic.	Verify the intra-procedure anesthesia record accurately and comprehensively documents that the patient received appropriate ventilation monitoring and care consistent with established standards. <u>Evaluating Compliance</u> Review policies for: Requirement for complete documentation of intra-procedure anesthesia monitoring and care Specification of required monitoring parameters and documentation frequency Documenting standards for interventions and patient responses Interview anesthesia providers about monitoring parameters and documentation standards Observe practice to ensure continual observation of clinical signs for adequate ventilation Review clinical records (anesthesia record) for: Continuous ventilation monitoring (e.g., ETCO₂, respiratory rate) Responses to any ventilation alarms or abnormalities.
Sub-section I: Transfer to Post-Anesthesia Care Unit (PACU)						
8-I-1		B	C-M	C	The operating room may be used for patient recovery if only one operation is scheduled that same day, or if the recovering patient meets all discharge criteria prior to beginning the next operation, or if there is another operating room available for the next operation.	Verify patient recovery is permitted within the operating room (OR) only when specific criteria are met and all applicable PACU standards are maintained. This option does not eliminate the requirement for a dedicated PACU where mandated by standards or regulations. When the OR is used for recovery, it must fully comply with all PACU requirements for equipment, monitoring, staffing, and documentation. <u>Evaluating Compliance:</u> Review policies for: Criteria for use of the OR for patient recovery Standards for staffing, equipment, and monitoring requirements for OR recovery Interview staff regarding recovery in OR criteria and equivalent PACU monitoring/documentation standards Observe practice of recovery in OR to ensure adherence to PACU standards Review facility layout to confirm compliance with spatial requirements When a patient is recovered in the OR, review clinical records for evidence of: Handoff to receiving staff member Patient condition at transfer Recovery start and end times Vital signs and assessments during recovery

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							Confirmation all discharge criteria were met (e.g., no shortened recovery period to start next case)
8-I-2		B	C-M	C	Patients transferred to the PACU will be continually evaluated and monitored as needed during transport.		Verify patients are continuously evaluated and monitored during transport to the PACU to ensure patient safety. If recovery occurs within the operating room, document the handoff process to begin the recovery period to ensure continuity of care. <u>Evaluating Compliance:</u> Review policies for: Continuous monitoring and evaluation during patient transport to the PACU Documentation requirements for handoff communication if patient is recovered in the OR Interview staff regarding transport monitoring, handoff procedure, and documentation standards Observe transport and handoff processes to ensure compliance Review clinical records for evidence of monitoring during transport, including: Vital signs at departure and arrival Oxygenation status Level of consciousness Any interventions during transport When a patient is recovered in the OR, ensure documentation includes: Handoff to receiving staff member Patient condition at transfer Recovery start and end times Vital signs and assessments during recovery.
8-I-3		B	C-M	C	Patients transferred to the PACU are accompanied by an anesthesia professional who is knowledgeable about the patient.		Verify an anesthesia professional accompanies the patient during transfer to the PACU and remains until the receiving staff (or team) accepts care. The facility must define how this handoff is documented in the clinical record to ensure continuity of care and patient safety. <u>Evaluating Compliance:</u> Review policies for: Requirement that an anesthesia professional accompanies the patient to the PACU Process for patient transfer to the PACU Required handoff elements (e.g., patient condition, anesthesia details, medications, complications). Interview staff regarding patient accompaniment and handoff protocols

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							Observe transfer practices to ensure compliance with accompaniment/handoff process Review clinical records (anesthesia records) for evidence of: - Time of transfer - Handoff to PACU staff - Patient condition at transfer - Summary of intraoperative course - Anesthesia professional's signature/authentication.
8-I-4		B	C-M	C	Patient transfer to the PACU will include the transmission of a verbal report on the patient to the PACU nurse accepting care of the patient from the anesthesia professional who accompanies the patient to the PACU. The clinical record must include documentation that the verbal report was completed.		Verify continuity of care and safe transfer of responsibility by requiring a clear, complete verbal report from the anesthesia professional to the PACU nurse. This handoff must include all essential information about the patient's condition, surgical/anesthetic course, and immediate care needs. The anesthesia professional must remain in the PACU until the PACU nurse accepts responsibility for the patient's care. <u>Evaluating Compliance:</u> Review policies for: - Standardized process for patient transfer to the PACU and handoff process - Mandate that anesthesia professional remains with patient until care is accepted by the PACU staff - Required elements of verbal report (e.g., patient condition, procedure(s), anesthesia details, medications, complications) - Interview staff regarding handoff protocols and report to PACU staff - Observe anesthesia staff handing off patient to PACU staff - Review clinical records (anesthesia records) for evidence of: - Time of transfer and condition of patient - Time of handoff to PACU staff and summary of intraoperative course - Anesthesia professional's signature/authentication.
8-I-5		B	C-M	C	Patient transfer to the PACU will include the transfer of information concerning the preoperative condition of the patient, the invasive procedure, related medication, and the anesthesia course.		Verify the safe and complete transfer of information occurs when the patient is moved to the PACU. This handoff must include all essential details about the patient's condition, surgical and anesthetic course, and immediate care needs to ensure continuity of care and patient safety. Evaluating Compliance: Review policies for: - Standardized process for patient transfer to the PACU and handoff process - Required elements of verbal report (e.g., patient condition, procedure(s), anesthesia details, medications, complications)

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							Mandate both anesthesia and PACU staff participate in the handoff process Interview staff regarding handoff protocols, required elements, mutual participation Observe handoff process Review clinical records (anesthesia records) for evidence handoff process, including: - Time of transfer and handoff - Key information communicated - Sign-off by both anesthesia and PACU staff Confirm the handoff documentation aligns with the patient's intraoperative and immediate postoperative condition
8-I-6		B	C-M	C	Patient transfer to the PACU will include an anesthesia professional who remains in the post-anesthesia area until the post-anesthesia care nurse accepts responsibility for the patient.		Verify continuity of care and a clear transfer of responsibility and accountability from the anesthesia team to the PACU nurse. The anesthesia professional must remain with the patient until the PACU nurse formally accepts care, ensuring all critical information is communicated and the patient is stable. <u>Evaluating Compliance:</u> Review policies for: - Standardized process for patient transfer to the PACU and handoff process - Mandate that anesthesia professional remains with patient until care is accepted by the PACU staff - Required elements of verbal report (e.g., patient condition, procedure(s), anesthesia details, medications, complications) - Documentation standards for the transfer of care (signatures/electronic authentication from both parties) Interview staff regarding: - Handoff protocols and roles - Understanding that anesthesia professional must remain in the PACU until PACU staff accepts patient Observe anesthesia staff handing off patient to ensure s/he remains until care is transferred Review clinical records for evidence of: - Time of handoff and acceptance - Summary of the patient's condition and intraoperative course - Vital signs and stability at the time of transfer - Signatures/electronic authentication from anesthesia professional and PACU staff.
8-I-8		B	C-M	C	The PACU is available to recover all patients after anesthesia administration.		Verify the facility is adequately constructed, equipped, and staffed to ensure comprehensive post-anesthesia monitoring and assessment

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							for all patients. Documentation must reflect individualized care, ongoing evaluation, and adherence to facility-defined protocols, including monitoring for patients meeting discharge criteria but awaiting transportation. <u>Evidence of Compliance:</u> Review policies for: Requirements for post-anesthesia monitoring and assessment tailored to patient needs Documentation methods (e.g., forms, progress notes) and frequency of assessments Directive for continued monitoring for patients awaiting discharge transportation Review documents: Select a few (random) days from the surgery schedule Cross-check with PACU staffing schedules Confirm adequacy of PACU staffing for procedure volume Interview staff regarding PACU staffing, adequacy of recovery area, and essential monitoring equipment Observe: PACU is present PACU is available and ready.
8-I-9		B	C-M	C	If a patient is not sent to PACU, there is a specific order for the variance that is documented on the record.		Verify the facility process when a patient is not sent to the PACU. <u>Evidence of Compliance:</u> Review policies for: Requirements for post-anesthesia monitoring and assessment tailored to patient needs Process for when a patient does not go to PACU Review clinical record: Select a patient that does not go to the PACU Review order for variance is present Interview staff regarding patients that do not go to PACU.
Sub-section J: Post-Anesthesia Care Unit (PACU) Documentation							
8-J-1		B	C-M	C	PACU documentation includes the patient's time of arrival in the PACU, or when recovery time started if the patient is recovered in the OR.		Verify the safe arrival of the patient to the PACU through accurate documentation of the recovery phase start time. This includes verifying patient stability during transfer and initiating timely post-anesthesia care. <u>Evaluating Compliance:</u> Review policies for:

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							Process for patient handoff from anesthesia staff to PACU staff (including report) Requirement to document the patient's arrival time (and start of post-anesthesia phase) Mandate for timely initiation of post-anesthesia monitoring and care Interview staff regarding knowledge of: Process for patient arrival (handoff, recording arrival time, prompt initiation of monitoring and care) Process for patient recovery in the OR (no transport, but clear documentation shift to PACU procedures) Observe transfer and arrival processes to ensure compliance Review clinical records for evidence of: Time of patient arrival in the PACU Patient condition and stability upon arrival Prompt initiation of post-anesthesia monitoring.
8-J-2	B	C-M	C		The patient's post-surgical condition must be assessed and documented in the clinical record by a physician, other qualified practitioner, or a registered nurse with, at a minimum, post-operative care experience in accordance with applicable State health and safety laws, standards of practice, and facility policy.		Verify postoperative assessments are performed by qualified personnel (e.g., physicians, qualified practitioners, or registered nurses with postoperative care experience), as permitted by state/national law, professional standards, and facility policy. <u>Evaluating Compliance:</u> Review policies for: Defining the personnel qualified to performing postoperative assessments Alignment with state laws and professional standards for postoperative care Interview staff regarding postoperative assessment protocols & qualifications/competency for assessment Observe postoperative assessment practice to ensure compliance with policy Review clinical records for evidence of: Assessments are completed in a timely manner, according to established protocols (or physician orders) Patient's postoperative condition & stability Name/credentials of staff assessing the patient Date/time of assessment Confirm anesthesia recovery assessment is performed by a qualified anesthesia professional.

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8-J-4		B	C-M	C	PACU documentation includes a record of all medications given to a patient, including date, time, dose, and route of administration.	Verify all medications administered in the perioperative and postoperative periods are given safely, accurately, and documented completely to prevent errors, ensure patient safety, and maintain regulatory compliance. <u>Evaluating Compliance:</u> Review policies for: Requirement for safe medication administration practices (right patient, drug, dose, route, time) Documentation standards for administered medications (name, dose, route, time, and administering staff) Directive to document medication administration as close to administration time as possible Verification process for independent double-checks for high-risk medications (e.g., insulin) Interview staff regarding protocols for medication administration and documentation Observe medication administration practices to ensure compliance with policy Review clinical records for evidence of timely and accurate documentation, including: Medication name and strength, dose, and route administered Date/time of administration Identity of the administering staff Independent double-checks for high-alert medications (when applicable).
8-J-5		B	C-M	C	PACU documentation includes a record in which all intravenous fluids given post- operatively are recorded.	Ensure all intravenous (IV) fluids are administered safely, accurately, and documented completely to maintain fluid balance, support patient stability, and prevent complications such as fluid overload or electrolyte imbalances. <u>Evaluating Compliance:</u> Review policies for: Requirement for safe IV fluid administration practices (right patient, drug, dose, route, time) Documentation standards for IV fluids (type, volume, rate, start/stop time, and administering staff) Directive to document medication administration as close to administration time as possible Monitoring for patient response and adjustments based on clinical status Interview staff regarding protocols for IV fluid administration and documentation

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							Observe IV fluid administration practices to ensure compliance with policy Review clinical records for evidence of timely and accurate documentation, including: - Type of fluid - Total volume infused - Infusion rate - Start and stop times - Identity of the administering practitioner - Patient monitoring and response to fluid administration.
8-J-6		B	C-M	C	PACU documentation includes a record of monitoring and assessment of: - Post-operative vital signs, including temperature, heart rate, respirations, and blood pressure; - Mental status; - Airway patency, ventilation, and oxygen saturation; and, - Pain, nausea and vomiting, hydration, drainage, and bleeding, as applicable. Patient status is recorded until the patient is discharged from the facility.		Verify comprehensive post-anesthesia monitoring and assessment for all patients recovering from general anesthesia, regional anesthesia, or moderate/deep sedation. Documentation must reflect individualized care, ongoing evaluation, and adherence to facility-defined protocols, including monitoring for patients meeting discharge criteria but awaiting transportation. <u>Evaluating Compliance:</u> Review policies for: - Requirement for post-anesthesia monitoring and assessment tailored to patient needs - Documentation forms (e.g., forms, progress notes) and frequency of assessments - Directive for continued monitoring for patients awaiting discharge transportation - Interview staff regarding monitoring protocols, individualized assessment, and discharge waiting procedures - Observe monitoring and documentation practices for compliance - Review clinical records for evidence of complete and accurate PACU documentation, including: - Vital signs at facility-defined intervals - Level of consciousness and pain assessment - Oxygenation and ventilation status - Fluid balance and medication administration - Ongoing assessments until discharge - Monitoring for patients awaiting transportation.
8-J-9		B	C-M	C	Post-operative progress notes are recorded.		Verify complete documentation of the postoperative phase of care in the PACU, capturing all aspects of patient recovery, interventions, and responses. Documentation methods may include standardized forms, flow sheets, progress notes, or electronic records, as defined by facility policy.

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							<u>Evaluating Compliance:</u> Review policies for: Requirement for comprehensive documentation of patient progress in the PACU Requirement of essential documentation elements: vital signs, level of consciousness, pain assessment, medications, fluid administration, and patient responses Mandate that documentation of progress continues until patient meets discharge criteria Interview staff regarding essential documentation elements and frequency of documentation Observe staff documenting patient progress and ensure accuracy Review clinical records for evidence of complete and accurate documentation, including: Vital signs at facility-defined intervals Pain assessments, interventions, and patient responses Medication and fluid administration Level of consciousness and recovery progress Complications and interventions Discharge criteria being met (time).
8-J-10	A	B	C-M	C	There is a procedure/operative report completed by the surgeon/proceduralist, which includes procedure technique and findings.		Verify a complete procedure report or operative note is documented in the clinical record by the surgeon or proceduralist. This report must include details of the procedure, findings, and the patient's immediate postoperative status to ensure continuity of care and accurate medical records. <u>Evaluating Compliance:</u> Review policies for: Requirement for a complete procedure report or operative note for all surgical and invasive procedures Required elements: procedure details, findings, specimens, complications, and postoperative status Mandate that report must be completed by the surgeon or proceduralist Interview surgeons and proceduralists about report documentation requirements and timely completion Observe the documentation process to ensure compliance Review clinical records for evidence of complete, accurate, and timely reporting, that includes: Patient identification and procedure date Preoperative and postoperative diagnoses Detailed description of the procedure Findings and any complications

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							Specimens removed Estimated blood loss Patient's immediate postoperative condition Signature of the surgeon or proceduralist (hard copy or electronic authentication).
8-J-11		B	C-M	C	A written, accurate post-anesthetic care report is maintained.		Verify complete documentation of the postoperative phase of care in the PACU, capturing all aspects of patient recovery, interventions, and responses. Documentation methods may include standardized forms, flow sheets, progress notes, or electronic records, as defined by facility policy. <u>Evaluating Compliance:</u> Review policies for: Requirement for comprehensive documentation of patient progress in the PACU Requirement of essential documentation elements: vital signs, level of consciousness, pain assessment, medications, fluid administration, and patient responses Mandate that documentation of progress continues until patient meets discharge criteria Interview staff regarding monitoring, documentation elements, and frequency of documentation Observe staff documenting patient care and ensure accuracy Review clinical records for evidence of complete and accurate documentation, including: Vital signs at facility-defined intervals Pain assessments, interventions, and patient responses Medication and fluid administration Level of consciousness and recovery progress Complications and interventions Discharge criteria being met (time).
Sub-section K: Discharge							
8-K-4		B	C-M	C	Approved and standardized discharge criteria are used and recorded (e.g. Aldrete score).		Verify patients are safely discharged from PACU using an approved, standardized, objective assessment tool, such as the Aldrete scoring system (or a comparable tool), to determine readiness for discharge to a second-stage recovery area or home. Staff use of the tool must align with facility-defined standards, including the minimum number of times assessments are performed before patient readiness for discharge can be determined. <u>Evaluating Compliance:</u>

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							Review policies for approval of: - Discharge assessment tool (e.g., Aldrete) with objective measures - Discharge criteria (parameters for VS, consciousness, mobility, pain control, and oxygenation) - Performance standards (minimum times criteria must be assessed before discharge) Interview staff regarding discharge assessment process Observe practice to ensure thorough patient assessment and compliance with policy Review clinical records for evidence of discharge assessment using the facility's approved tool, including: - Vital sign stability - Level of consciousness - Pain and nausea control - Mobility and functional status - Oxygenation without supplemental oxygen (if applicable) - Confirmation that ≥ minimum assessments are performed and discharge criteria are met.
8-K-6	B	C-M	C		A qualified and credentialed individual determines that the patient meets discharge criteria based upon input from the PACU staff. That individual's name must be noted on the record, signed by that individual with the time of discharge.		Verify patients are safely discharged after a qualified and credentialed individual (e.g., anesthesia professional, surgeon/proceduralist) evaluates and documents their recovery from anesthesia, confirming appropriate physiological stability and readiness for discharge. <u>Evaluating Compliance:</u> Review policies for: - Requirement for discharge evaluation by qualified staff (anesthesia professional, surgeon/proceduralist) - Defines discharge criteria (stable VS, consciousness level, pain control, and absence of complications) - Documentation standards for the evaluation and discharge readiness (signature, credentials, time/date) Interview staff regarding discharge protocols Observe the discharge process to ensure compliance with policy Review clinical records for evidence of discharge evaluation, including: - Assessment of recovery from anesthesia (e.g., Aldrete score or comparable tool) - Vital sign stability - Pain and nausea management - Mobility and functional status - Discharge instructions and follow-up care - Evaluator's signature, credentials and date/time Confirm discharge occurs only after criteria are met and documented.

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8-K-8	A	B	C-M	C	Written discharge instructions, including procedures for emergency situations, are given to the responsible adult who is responsible for the patient's care and transportation following a procedure or the patient has received discharge instructions prior to receiving sedation/anesthesia. A signed copy of the instructions is maintained in the patient's chart. The standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.		Verify patients and/or responsible adult receive comprehensive written discharge instructions to support safe recovery. Instructions must cover all critical post-procedure care elements and be communicated to the patient's care giver for the immediate postoperative period. Facilities must have clear policies addressing discharge transportation requirements and documentation of any patient deviations from these policies. <u>Evaluating Compliance:</u> Review policies for: Requirement that written discharge instructions are provided to patient/responsible adult and care provider Defines "responsible adult" based on capability, not just age Specifies instructions include: Discharge diagnosis and follow-up appointments Emergency contact information Diet, activity, and wound care instructions Medication management (resuming pre-op and new prescriptions) Warning signs of complications Supervision requirements Interview staff about discharge instruction protocols, transportation policies, and "responsible adult" criteria Observe discharge process to ensure instruction delivery and policy compliance Review clinical records for evidence of: Written discharge instructions to the patient/responsible adult (with all required elements) Patient/responsible adult acknowledgment.
8-K-10		B	C-M	C	Patients receiving anesthetic agents other than topical or local anesthesia must be supervised in the immediate post-discharge period by a responsible adult for at least 12 to 24 hours, depending on the procedure and the anesthesia used.		Verify the facility promotes safe patient recovery by providing clear directives for patient supervision in the immediate postoperative period (12-24 hours, depending on the type of procedure and anesthesia used). <u>Evaluating Compliance</u> Review policies for: Directive for patient supervision by a responsible adult in the immediate postoperative period Defines "responsible adult" based on capability, not just age Mandatory inclusion of requirement in pre-op education and patient discharge instructions Observe discharge process to ensure supervision requirement is reinforced and a responsible adult is present

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							Review clinical records for evidence of requirement for responsible adult supervision in written instructions.
8-K-14		B	C-M	C	The patient is transported in a suitable vehicle with a responsible adult.		Verify patients are discharged and transported in a suitable vehicle accompanied by a responsible adult capable of providing post-procedure care and assistance. The facility must establish clear policies defining "suitable vehicle" and "responsible adult," and require documentation of compliance or exceptions. <u>Evaluating Compliance:</u> Review policies for: Requirement for patient transport via suitable vehicle with a responsible adult Definitions of "suitable vehicle" (e.g., personal car, ambulance, medical transport) Definition of "responsible adult" (e.g., capable of providing care, not rideshare/taxi drivers) Prohibition of discharge without adherence to requirements unless a documented exception exists Interview staff about transportation protocols and handling/documenting deviations from policy Observe discharge process to ensure compliance with transportation protocols Review clinical records for evidence of: Discharge instructions acknowledged by the responsible adult (or patient) Patient discharge with accompaniment of responsible adult Additional documentation with deviation from policy: Physician order for patient discharge without suitable vehicle and/or responsible adult Patient's informed acknowledgement Documentation of alternative safety measures (staff assisted patient to the vehicle).
8-K-15	A	B	C-M	C	Patients receiving only local anesthesia without sedation may transport themselves.		Verify patients who receive only local anesthesia without sedation are permitted to transport themselves post-procedure, provided they meet facility-defined criteria for safe self-transportation. The facility must establish clear policies distinguishing these cases from those requiring accompaniment. <u>Evaluating Compliance:</u> Review policies for: Self-transportation allowed after local anesthesia without sedation Definition of eligibility criteria (e.g., stable vital signs, no dizziness,

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							clear cognition) Prohibition of self-transport if sedation or systemic medications are administered Interview staff regarding self-transportation policies and assessment criteria Observe discharge process to ensure compliance with self-transportation policy Review clinical records for evidence of: - Type of anesthesia administered (local only, no sedation) - Assessment confirming patient stability for self-transport - Patient acknowledgment of self-transportation instructions.
8-K-16		B	C-M	C	The facility must have a policy for discharge from the recovery area with approved and standardized discharge criteria.		Verify the facility has a written policy for patient discharge from the recovery area that includes standardized, objective criteria to determine when a patient is medically ready for safe discharge. These criteria must be consistently applied and documented for every patient. <u>Evaluating Compliance:</u> Review policies for: - Standardized measures to assess readiness for discharge (e.g., Aldrete, modified PADSS, facility tool) - Confirm use of objective measures such as: - Stable vital signs - Adequate oxygenation - Return to baseline consciousness - Controlled pain and nausea - Ability to ambulate (if applicable) - Specifying who is authorized to make discharge decision Interview staff regarding discharge criteria and who can order patient discharge Observe the discharge process to ensure consistent application of the policy Review clinical records for evidence that discharge criteria were met prior to discharge, including: - Assessment of each criterion (e.g., vital signs, pain level, mobility) - Time of discharge - Signature of authorized staff member.
Sub-section L: Operative Log							
8-L-1	A	B	C-M	C	A separate dated operative log of all cases is maintained, either in a sequentially numbered, bound journal from which pages may not be removed, or in a tamper-proof,		Verify all surgical case information is accurately collected, tracked, and secured as part of the facility's quality management activities. The operative log, whether electronic or paper-based, must include

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					secured computer record consistent with state and federal law. This log must be kept in the facility.		required data elements and be protected against tampering or unauthorized access. <u>Evaluating Compliance</u> Review policies for: Required maintenance of an operative log for all surgical or procedural cases Required data elements (e.g., patient identifier, procedure, surgeon, anesthesia type, complications). Requirements for operative log security: Electronic: password protection, access controls, audit trails Paper: secure storage in facility, sequential numbering, tamper-evident binding, retention Review operative log for: Inclusion of required elements Evidence of log security: Electronic: access controls and audit trails functional Paper: sequential numbering, no evidence of tampering Interview staff about log entry procedures, timely entries, and security protocols.
8-L-3	A	B	C-M	C	An operative log must include the date of procedure.		Verify the facility maintains a complete and accurate accounting of all cases performed in the facility through a secure, detailed operative log. This log serves as a critical tool for quality improvement, regulatory compliance, and facility management. <u>Evaluating Compliance</u> Review policies for operative log required elements Review operative log to ensure inclusion of date for all procedures recorded Interview staff about log entry procedures, data requirements, timeliness and accuracy.
8-L-4	A	B	C-M	C	An operative log must include the patient's name and date of birth or other identification number.		Verify the facility maintains a complete and accurate accounting of all surgical cases using a secure operative log that includes at least two (2) patient identifiers (e.g., name and date of birth, or name and a facility-approved identifier) for each entry. This ensures proper patient identification, supports quality tracking, and meets regulatory requirements. <u>Evaluating Compliance:</u> Review policies for: Operative log required elements Mandate for use of two (2) patient identifiers per log entry (e.g.,

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							name/DOB or name/facility-approved ID) Review operative log to ensure inclusion of patient identifiers for all procedures recorded Interview staff about log entry procedures, data requirements, timeliness and accuracy.
8-L-5	A	B	C-M	C	An operative log must include record of surgery(ies) and other invasive procedures to be conducted during the case.		Verify the facility maintains a complete and accurate operative log that records all surgeries and invasive procedures performed in the facility. The log must include detailed, case-specific information to support quality improvement, regulatory compliance, and patient safety initiatives. <u>Evaluating Compliance:</u> Review policies for: Operative log required elements Mandate for describing all procedure(s) performed (e.g., description, CPT codes) Review operative log to ensure inclusion of all procedures performed Interview staff about log entry procedures, data requirements, timeliness and accuracy.
8-L-6	A	B	C-M	C	An operative log must include the surgeon/proceduralist's name.		Verify the facility maintains a complete and accurate operative log that includes the surgeon/proceduralist's name for every surgical and invasive procedure performed to maintain a complete and accurate accounting of cases. This supports accountability, quality tracking, and regulatory compliance. <u>Evaluating Compliance:</u> Review policies for: Operative log required elements Mandate requiring the surgeon/proceduralist's name for all procedures Review operative log to ensure inclusion of surgeon/proceduralist's name for of all procedures performed Interview staff about log entry procedures, data requirements, timeliness and accuracy.
8-L-7	A	B	C-M	C	An operative log must include a record of the type of anesthesia used.	-	Verify the facility maintains a complete and accurate accounting of all cases performed in the facility through a secure, detailed operative log. This log serves as a critical tool for quality improvement, regulatory compliance, and facility management. <u>Evaluating Compliance</u> Review policies for operative log required elements

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							Review operative log to ensure inclusion of date for the type of anesthesia used Interview staff about log entry procedures, data requirements, timeliness and accuracy.
8-L-8	A	B	C-M	C	An operative log must include the name of person(s) administering anesthesia.	-	Verify the facility maintains a complete and accurate accounting of all cases performed in the facility through a secure, detailed operative log. This log serves as a critical tool for quality improvement, regulatory compliance, and facility management. Evaluating Compliance Review policies for operative log required elements Review operative log to ensure inclusion of date for the names of the persons administering anesthesia Interview staff about log entry procedures, data requirements, timeliness and accuracy.
8-L-9	A	B	C-M	C	An operative log must include the name of person(s) assisting physician (e.g. additional physician, registered nurse - circulating or scrubbed, scrub tech, physician's assistant, dental assistant, anesthesia assistant, or other qualified personnel).		Verify the facility maintains a complete and accurate accounting of all cases performed in the facility through a secure, detailed operative log. This log serves as a critical tool for quality improvement, regulatory compliance, and facility management. Evaluating Compliance Review policies for operative log required elements Review operative log to ensure inclusion of date for the names of the persons assisting the physician Interview staff about log entry procedures, data requirements, timeliness and accuracy.

SECTION 9: GOVERNING BODY

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Sub-section A: Governing Body							
9-A-1	A	B	C-M	C	The facility has a governing body with full legal responsibility for determining, implementing, and monitoring policies governing facility's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that the facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan.		Verify that the facility has a designated governing body that provides oversight for all facility operations. The governing body is responsible for establishing facility policies, ensuring that those policies are implemented, and monitoring compliance with them. It must also periodically review and assess the facility's policies to determine whether revisions are necessary. The governing body is responsible for: - Direct oversight of the Quality Assessment and Performance Improvement (QAPI) program - Ensuring the overall quality of healthcare services provided by the facility - Ensuring the safety and integrity of the facility environment - Developing, approving, and maintaining a comprehensive disaster preparedness plan In the case of a facility that has one (1) owner, that individual constitutes the governing body. <u>Evaluating Compliance:</u> Review governing body minutes for evidence of how the policies are implemented and monitored Review governing body/quality minutes for evidence of QAPI oversight Interview staff on how frequently the governing body meets Review administrative documents to see if the governing body has delegated operational responsibilities to a manager Review disaster policies and meeting minutes to verify governing body's role in disaster preparedness.
9-A-5	A	B	C-M	C	The governing body/facility leadership has defined the scope and intended use of the facility, as well as the appropriate ancillary support needed for the intended surgical procedures.		Verify that the facility has a formal, documented scope of services that clearly states things such as: - What types of procedures are performed - Intended use of the facility - Levels of anesthesia allowed - Patient acuity criteria - Ancillary support needed (e.g., laboratory, radiology, staffing, linen services, waste management services) <u>Evaluating Compliance:</u>

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							Review scope of service document Review governing body/facility leadership meeting minutes approving the document Interview staff to verify current practice matches scope of services.
9-A-7	A	B	C-M	C	The governing body/facility leadership: Is regulated by a governing rules and regulations or bylaws that has the consent of each member or the solo (1) physician.		Verify all members of the governing body formally acknowledge and adhere to the roles and responsibilities defined in the facility's bylaws. This promotes accountability, effective governance, and organizational alignment. Evaluating Compliance Review Governing Body (GB) document (bylaws) for: - Clear outlines of roles, responsibilities, and expectations for all GB members - Process for onboarding new members and periodic review of roles - Requirement for formal acknowledgment of responsibilities (e.g., signed agreements) Review GB meeting minutes for evidence of: - Discussions or training on roles and responsibilities - Formal acceptance of roles by new members - Periodic reviews of the governance structure Confirm documentation of member agreements (e.g., signed forms, meeting motions) Interview GB members to confirm understanding of their roles and responsibilities.
9-A-10	A	B	C-M	C	The governing body/facility leadership: Sets policy on how individual staff deal with each other and external parties.		Verify the governing body develops and enforces policies and procedures that establish and maintain accountability for staff behavior, fostering a culture of professionalism, safety, and ethical conduct throughout the facility. Evaluating Compliance Review policies for: - Defined expected staff behavior (codes of conduct, ethical standards, and disciplinary procedures) - Outline of clear consequences for violations and mechanisms for reporting concerns - Mandate for annual review (and updates when required) Review GB meeting minutes for evidence of: - Development, approval, and periodic review of behavior-related policies - Discussions of staff accountability, incident reports, or disciplinary actions - Efforts to promote a culture of accountability and professionalism

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							Interview staff regarding behavioral expectations, reporting mechanisms, & accountability measures Observe staff interactions for compliance with behavioral standards and professionalism.
9-A-11	A	B	C-M	C	The governing body/facility leadership: Sets policy on staff's role in properly dealing with patients.		Verify the governing body develops and enforces policies and procedures that establish clear customer service expectations and maintain accountability for facility staff. This fosters a culture of professionalism, patient-centered care, and continuous improvement in service delivery. <u>Evaluating Compliance</u> Review policies for: Customer service standards (communication, responsiveness, and patient interaction protocols) Staff training requirements, performance evaluation criteria, and mechanisms for patient feedback Procedures for addressing service complaints and improving service quality Review GB meeting minutes for evidence of: Development, approval, and periodic review of customer service policies Discussions of patient satisfaction data, complaints, or service improvements Initiatives to promote a patient-centered culture and staff accountability Interview staff to assess: Understanding of customer service expectations and training received Awareness of feedback mechanisms Confidence in fair enforcement of standards Observe staff interactions with patients for professionalism, empathy, and adherence to service protocols.
9-A-12	A	B	C-M	C	The governing body/facility leadership is responsible for the operation and performance of the facility including: Determining the mission and goals of the facility, including the types of services provided and for determining, implementing, and monitoring policies governing the facility's total operation.		Verify the governing body is explicitly accountable for the facility's operation and performance, with clearly defined roles, responsibilities, and oversight mechanisms. This includes strategic decision-making, resource allocation, and monitoring of quality and safety outcomes. <u>Evaluating Compliance</u> Review policies for: Bylaws (or charter) defining the GB's responsibilities for facility operation and performance Mechanisms to monitor key performance indicators (e.g., patient

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							outcomes and satisfaction, financial) Processes for addressing underperformance or operational issues Review GB meeting minutes for evidence of: Regular review of operational/performance reports (e.g., quality metrics, financial statements) Decisions related to resource allocation, strategic planning, and risk management Actions taken to address performance gaps or operational challenges Interview senior leadership regarding the GB's engagement and accountability Verify the GB receives regular, comprehensive reports on facility performance.
9-A-14	A	B	C-M	C	The governing body/facility leadership is responsible for the operation and performance of the facility including: Adopting policies and procedures for the orderly conduct of the facility and for ensuring procedures are provided in a safe and effective manner.		Verify the governing body is accountable for developing, implementing, and overseeing policies and procedures that guarantee the orderly and safe operation of the facility. This includes establishing systems to ensure all procedures are performed safely, effectively, and in compliance with applicable standards and regulations. <u>Evaluating Compliance</u> Review policies to ensure: Procedures cover critical aspects of facility operations (clinical care, safety protocols, and admin functions) Procedures align with evidence-based practices and regulatory requirements Regularly reviewed, updated, and accessible to all staff Review GB meeting minutes for evidence of: Development, approval, and periodic review of policies and procedures Discussions of safety incidents, quality metrics, and corrective actions Decisions regarding resource allocation to support safe and effective care Interview senior leadership and to: Assess understanding of (and adherence to) policies and procedures Determine if staff feel supported in reporting concerns.
9-A-16	A	B	C-M	C	The governing body/facility leadership is responsible for the operation and performance of the facility including: Approving all arrangements for ancillary medical care delivered in the facility, including laboratory, radiological, pathologic, and anesthesia services.		Verify the governing body holds the final legal and strategic oversight for ancillary medical care, by approving contracted services and annual evaluating the services provided by the external entity contracted for the delivery of laboratory, radiological, pathologic, and anesthesia services.

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							<u>Evaluating Compliance:</u> Review policies for: Requirement for the GB to approve all contracted service providers of ancillary medical care Procedures for assessing alignment with evidence-based practices/outcomes and regulatory requirements Directives to review contracts at least annually Review GB meeting minutes for evidence of: Initial approval, and annual review for all external contracts for providers of ancillary medical care Discussions of safety incidents, quality metrics, and improvement when corrective actions were taken Interview senior leadership regarding process for approving contracts for external provision of services.
9-A-17	A	B	C-M	C	The governing body/facility leadership must ensure that all outside services are provided in a safe and effective manner.		Verify when the facility contracts with third parties for provision of the facility's patient care services, including the facility's environment, that the facility assures that the contract services are provided safely and effectively. Contractor services must be included in the facility's QAPI program. Such contracting does not relieve the governing body from its responsibility to oversee the delivery of these facility services. <u>Evaluating Compliance:</u> Ask facility for a complete list of current contracted services Review personnel files of contract personnel to determine required elements are present Interview staff to see how the safety and effectiveness of the contracted service is measured Review QAPI plan and quality meeting minutes.
9-A-20	A	B	C-M	C	The facility's policies and services are developed with the advice of a group of professional personnel that includes one or more physicians / dentists, one or more physician assistants / nurse practitioners / mid-level clinical personnel, and at least one community member who is not a member of the clinic staff.		Verify a multidisciplinary professional group (e.g., clinicians, administrators, technical staff) and at least one community representative collaborate to advise on the facility's policies and services. This inclusive approach promotes patient-centered care, community engagement, and alignment with diverse stakeholder needs. <u>Evaluating Compliance:</u> Review policies for: Requirement for multidisciplinary community input for development/review of facility policies and services Definition of composition of the advisory group (e.g., roles, expertise, community representation)

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							Outline of the frequency of meetings and mechanisms for incorporating feedback Review GB meeting minutes for evidence of: - Establishment and ongoing engagement of the multidisciplinary advisory group - Inclusion of community representative(s) in discussions and decisions - Integration of advisory feedback into policy and service improvements Interview advisory group members to confirm their roles and contributions Assess whether feedback from the group leads to tangible changes in policies or services.
9-A-21	A	B	C-M	C	The policies, procedures, and processes adopted by the governing body/facility leadership are reviewed and revised at least annually and in accordance with any implementation timelines adopted by the governing body/facility leadership.		Verify all policies, procedures, and processes are reviewed at least annually and updated as needed to reflect current standards, regulations, and best practices. This ongoing review ensures operational compliance, patient safety, and continuous improvement. <u>Evaluating Compliance</u> Review policies for: - Requirement for an annual review (minimally) of all policies, procedures, and processes - Directive to document each review, including dates, participants, and changes made - Mandate that updates are made promptly when new regulations, standards, or best practices emerge Review GB meeting minutes for evidence of: - Annual reviews of policies, procedures, and processes - Discussions and approvals of updates or revisions - Documentation of effective dates for revised policies Interview staff regarding awareness of the review process and their role in it Confirm staff can: - Access current policies - Have received training on updated policies and procedures (when applicable).
9-A-22	A	B	C-M	C	The governing body/facility leadership must document the content of any policies, procedures, or processes implemented in key functional areas of the facility. The governing body/facility leadership must document its approval of the policies, procedures, or processes.		Verify facility leadership is explicitly accountable for the development, documentation, approval, and maintenance of all facility policies, procedures, and processes. This includes establishing clear ownership, review cycles, and approval mechanisms to ensure consistency, compliance, and operational effectiveness.

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							<u>Evaluating Compliance</u> Review policies for: Designated leadership roles/responsibilities for policy development, approval, and maintenance Procedures to documentation of approval (e.g., signatures, dates, version control) Requirement for regular review (e.g., annually) and updates Review GB meeting minutes for evidence of: Discussions and formal approvals of policies, procedures, or processes Designation of leadership accountability for specific policies or areas Periodic reviews/updates of existing policies Interview leadership and staff to assess understanding of policy ownership and approval processes Confirm staff access to current, approved policies and procedures.
9-A-23	A	B	C-M	C	The facility's leadership reviews and updates strategic objectives annually.		Verify the facility's leadership conducts an annual review and update of strategic objectives to align with evolving organizational goals, regulatory requirements, and community needs. This process supports continuous improvement, resource allocation, and long-term sustainability. <u>Evaluating Compliance:</u> Review policies for: Requirement for an annual review (minimally) of strategic objectives by leadership Process for developing, evaluating, and revising objectives (e.g., data analysis, stakeholder input, scans) Directive to document each review, including dates, participants, and changes made Review GB meeting minutes for evidence of: Annual discussions and approvals of strategic objectives Analysis of performance metrics (e.g., clinical outcomes, financial stability, patient satisfaction) Adjustments to objectives based on internal/external factors (e.g., regulatory changes, market trends) Interview staff regarding their involvement in the annual strategic review process, including: Awareness of current strategic objectives and their role in achieving them Whether objectives are communicated and integrated into departmental goals.

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9-A-26	A	B	C-M	C	The governing body/facility leadership is responsible for overseeing the program of risk management.		Verify the governing body and facility leadership are explicitly accountable for overseeing a comprehensive risk management program. This includes identifying, assessing, and mitigating risks to patient safety, data security, financial stability, and regulatory compliance. Leadership must ensure the program is proactive, integrated into daily operations, and continuously improved. <u>Evaluating Compliance:</u> Review policies for: Designation of the GB and leadership as responsible for overseeing the risk management (RM) program Processes for RM, including risk identification, assessment, mitigation, and reporting Requirement for regular review (e.g., quarterly) of risk reports and incidents Review GB meeting minutes for evidence of: Regular discussions of risk management reports, trends, and incidents Approval of risk mitigation strategies and resource allocation Evaluation of the program's effectiveness with adjustments (as needed) Review of RM documentation to ensure: Risk assessments, incident reports, and mitigation plans are documented and accessible Leadership reviews and signs off on risk reports and actions taken The program addresses clinical, operational, financial, and regulatory risks Interview leadership to assess their understanding of RM responsibilities Interview staff to confirm: Training is provided to report risks and incidents promptly RM is integrated into organizational culture and operations.
9-A-27	A	B	C-M	C	The governing body/facility leadership will designate a person or committee responsible for implementation and ongoing management of the risk management program.		Verify facility leadership is explicitly accountable for the development, implementation, and oversight of a comprehensive risk management (RM) program. This program must proactively identify, assess, and mitigate risks to patient safety, operational continuity, and regulatory compliance, with clear lines of authority and responsibility. <u>Evaluating Compliance:</u> Review policies for: Designation of leadership responsible for the RM program (e.g., Governing Body, CEO, Risk Mgr) Processes for risk identification, assessment, mitigation, and

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							reporting Requirement for regular review (e.g., quarterly) of risk data and program effectiveness Review GB meeting minutes for evidence of: Regular discussions of RM reports, trends, and incident analyses Approval of risk mitigation strategies and resource allocations Evaluation of program effectiveness and adjustments as needed Review organization chart for: Clear delineation of roles/responsibilities for RM (e.g., Risk Officer, Committee) Reporting lines accountability to leadership Interview leadership and RM staff to assess understanding of their roles and the program Interview staff to confirm: Training is provided to report risks and incidents promptly RM is integrated into organizational culture and operations.
9-A-28	A	B	C-M	C	The facility's risk management program must include the assessment of vulnerable patients.		Verify the facility's risk management (RM) program proactively identifies, assess, and mitigate risks to patient safety, including vulnerable patients. Patient intake should include a comprehensive evaluation of factors like age, health conditions, social determinants, and functional status to identify potential risks such as falls, neglect, or infection. <u>Evaluating Compliance:</u> Review policies for: Directive to perform prospective risk assessment upon admission Process for escalating positive findings (e.g., fall risk → colored wrist band → assisted ambulation) Mandatory reporting (e.g., abuse, neglect) Interview staff regarding: Understanding of vulnerability risks (physical/mental wellbeing, social determinants of health, safety) Process for accommodation (e.g., quiet environment for identified sensory sensitivities) Referrals and reporting mechanisms Observe for evidence of patient accommodation (e.g., accessible equipment, large print patient education materials, assistance with transfers).
9-A-29	A	B	C-M	C	All identified risks and adverse events must be logged and retained in a risk register (log) for tracking and trending over time.		Verify facility implementation of a comprehensive risk management (RM) program that includes formal identification and analysis of active risks (near misses) and adverse events to improve patient safety, meet regulatory and accreditation requirements, and reduce future

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							occurrences. The facility must analyzing this data for trends, so it may proactively address systemic issues rather than only reacting to individual incidents. Evaluating Compliance: Review policies for requirements to: Maintain a risk management log (written or electronic) Identify types of events to log and analyze (e.g., patient death or serious injury, events that resulted in unintended harm to the patient, near misses, patient complaints, harm from device failure or improper use) Define processes for risk identification, regular analysis (e.g., monthly, quarterly), mitigation, & reporting Review risk log for evidence that risk incidents and adverse events are documented, tracked, & trended Interview risk manager (or quality coordinator) regarding: Process for risk analysis and performance improvement Communication to governing body Implementation of risk reduction measures Interview staff for: Understanding of what constitutes a risk (near miss) or adverse event and how to report Confirmation that incidents/adverse events are analyzed and risk reduction measures are implemented.
Sub-section B: Transfer of the Patient							
9-B-3	A	B	C-M	C	The facility must have an effective procedure for the immediate transfer to a hospital for patients requiring emergency medical care beyond the capabilities of the facility.		Verify that the facility has an effective procedure for the immediate transfer of a patient to a local hospital when the patient experiences a medical emergency that the facility is not equipped to manage, or when the patient requires emergency care that exceeds the facility's 24-hour timeframe for care. An effective procedure for immediate emergency transfers must include: Policies and procedures that define: The circumstances that warrant an emergency transfer Who is authorized to make the transfer decision Required documentation that must accompany the patient Process ensuring the transfer is completed safely, efficiently, and with appropriate communication to the receiving hospital Provision of emergency care and initial stabilizing treatment within the facility's capabilities prior to transfer. Arrangements for immediate emergency transport, such as calling 911 for EMS services. Even when EMS is used, the facility remains responsible for direct communication with the receiving hospital to

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							ensure a safe and coordinated transfer. Evaluating Compliance: Review policy on emergency transfer of the patient Interview staff: How is this policy communicated to staff? Ask how a medical emergency would be handled Ask if there have been any transfers in the last 12 months Review clinical record of a transferred patient(s) for evidence that policy was followed.
Sub-section C: Extended Stays							
9-C-3		B	C-M	C	If the facility discharges patients to a recovery hotel following full recovery from anesthesia the facility has in place a protocol that identifies that the hotel being used for extended recovery of the patient: · Is less than thirty (30) minutes from a hospital where the physician has admitting privileges. · Has a trained registered nurse certified in BLS and ACLS, and a second BLS-certified staff member on duty at all times when there is a patient present in the hotel. · Has the ability to meet all special diet provisions of the patient. · Has a defibrillator or AED equipment. · Has first aid equipment. · Has an agreement for transportation to the hospital in an emergency as well as how an admission would be handled.		Verify the facility confirms safety protocols are met when discharging patients directly to a recovery hotel, to mitigate risk of adverse events postoperatively. Evaluating Compliance: Review policies regarding discharge directly to recovery hotels for directives to ensure hotels: Are < 30 minutes from hospital where physician has admitting privileges Have RN with current BLS/ACLS & another BLS-certified staff member on duty when patients present Can meet special dietary needs of patients (e.g., salt-restriction) Maintain a functional defibrillator (or AED) and first aid equipment/supplies Maintains agreement for patient transport to the hospital in an emergency Maintains procedures for patient transport/admission to hospital Review documents used to confirm recovery hospitals used meet compliance with requirements Interview staff regarding process to vet recovery hotels and periodically access compliance.
9-C-4		B	C-M	C	If overnight stays are permitted, the facility is in compliance with all applicable local, state/provincial, and national laws and regulations.		Verify that if the facility permits overnight stays, it complies with all applicable local, state/provincial, and national laws and regulations governing overnight care. Evaluating Compliance: Review licensure documents, certificates of occupancy, regulatory approvals, and inspection reports to confirm that the facility is authorized to provide overnight services Review policies to ensure the facility maintains fire safety, staffing,

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							patient monitoring, and environmental requirements associated with overnight stays Interview staff about the last overnight stays in the facility Review clinical record of at least one (1) overnight stay to verify safety requirements were in place

SECTION 10: QUALITY ASSESSMENT/QUALITY IMPROVEMENT/RISK MANAGEMENT

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-section A: Quality Assessment/Quality Improvement/Risk Management							
10-A-1		B	C-M	C	A licensed and qualified anesthesia professional supervising or providing care in the facility must participate in quality assessment/quality improvement and risk management in the facility.		Verify a licensed and qualified anesthesia professional participates in quality assessment/performance improvement (QAPI) and risk management to identify, mitigate, and monitor risks that are unique to the administration of anesthesia. The anesthesia professional must have privileges at the facility or supervise those who provide anesthesia services directly. <u>Evaluating Compliance:</u> Review policies for: Mandate for at least one (1) anesthesia professional (with current license) to participate in the facility's quality/risk activities Participation requirements (e.g., chart review, peer review, policy development, running emergency response drills, attendance GB meetings) Review Governing Board documents/meeting minutes to ensure evidence of participation Review personnel files for evidence of current license and eligibility to serve in this capacity (privileges to provide anesthesia services or supervisor of anesthesia professionals).
10-A-2	A	B	C-M	C	The governing body/facility leadership must identify the specific committee or individual(s) responsible for the development, implementation, and oversight of the quality assurance and risk management program.		Verify the facility appoints the individual (or committee) responsible for its quality assurance and risk management program to ensure a formal, structured, and accountable process for improving patient care. <u>Evaluating Compliance:</u> Review policies for: Directive to appoint the staff member (or committee) in charge of the facility's quality/risk activities Oversight requirements (e.g., chart review, peer review, policy development, reporting to the GB) Review Governing Board documents/meeting minutes for written appointment and GB participation Review documents (e.g., dashboards, spreadsheets) from QAPI program to verify trends have been reviewed and staff oversight

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Review organizational chart for evidence of staff appointment, oversight of QAPI program, and evidence of directional reporting.
Sub-section B: Quality Improvement Program							
10-B-2	A	B	C-M	C	The facility has a written quality improvement program implemented which includes surveys or projects to: · Monitor and evaluate patient care · Evaluate methods to improve patient care · Identify and correct deficiencies within the facility · Alert the facility's Quality Improvement Program to identify, track, trend, evaluate and resolve problems.		Verify the facility implements a written quality improvement (QI) program that includes systematic surveys, projects, and initiatives to monitor, evaluate, and improve patient care and safety. The program must involve staff at all levels, identify deficiencies, implement corrections, and demonstrate measurable improvements. <u>Evaluating Compliance</u> Review policies of QI program for: Goals and objectives aligned with patient safety and care standards Methods for data collection (e.g., surveys, audits, incident reports) Processes for analyzing data, identifying trends, and implementing corrective actions Defined roles and responsibilities for staff participation Confirm the program requires regular reviews (e.g., quarterly) and updates Interview staff regarding QI program surveys/projects and their roles within recent improvements.
10-B-6	A	B	C-M	C	The facility has a written quality improvement program that includes documentation of Peer Review meetings for the prior three (3) years, which must be available for the surveyor. Facilities with a monthly case volume of 50 or fewer cases must conduct peer review meetings no less than twice per year. Facilities with a monthly case volume in excess of 50 cases must conduct peer review meetings no less than quarterly.		Verify the facility implements a comprehensive Quality Improvement program to ensure patient safety, maintain quality of care, and meet accreditation and regulatory requirements. Physician peer-to-peer review provides a structured way for physicians to assess their colleagues' work, identify areas for improvement, and uphold professional standards and facility policy. <u>Evaluating Compliance</u> Review policies of QI program for: Criteria for selecting cases for peer review (e.g., complications, outliers, random sampling) Frequency of peer review meetings based on case volume (e.g., quarterly minimum) Documentation requirements for discussions, actions, and follow-up Confirm the program integrates peer review findings into broader QI initiatives Review of peer review documents and governing body meeting minutes for evidence of: Scheduled peer review meetings with documented attendance

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							(e.g., physicians, clinical staff) Case discussions (clinical outcomes, deviations, and opportunities for improvement) Actions taken (e.g., education, policy changes) and tracking of effectiveness Confirm the meeting frequency matches case volume (e.g., quarterly minutes for high-volume facilities) Interview clinical and QI staff to assess: Understanding of peer review processes and case selection criteria Awareness of recent peer review findings and implemented changes (if applicable) Participation in meetings and contributions to discussions.
10-B-19	A	B	C-M	C	The governing body/ facility leadership must ensure that the QAPI program is defined, implemented, and maintained by the facility.		Verify that the facility has an ongoing and effective QAPI program that is actively supported and directed by facility leadership. The governing body must assume responsibility for the design, implementation, and oversight of every phase of the QAPI program. The governing body must ensure that the facility's QAPI program: Is formally defined in writing and fully implemented Includes quality and patient safety indicators Specifies the indicator data to be collected, including what data will be collected, how it will be collected, and the frequency of collection Uses collected and analyzed data to drive performance improvement Evaluates the effectiveness of performance-improvement changes, and makes additional modifications when needed Clearly establishes that patient safety is a governing body priority, demonstrated not only through tracking all adverse events but also through processes that analyze causes and implement changes to prevent recurrence Has adequate resources, including qualified staff (internal or consultants), sufficient staff time, information systems, and necessary training to support the program <u>Evaluating Compliance:</u> Review QAPI for essential elements Review governing body minutes to verify discussion of QAPI elements Interview staff on how the governing body/facility leadership is involved in QAPI Interview facility leadership how it uses QAPI to improve performance Interview facility leadership on the details of the resources allocated to QAPI.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
10-B-24	A	B	C-M	C	The quality improvement program will demonstrate measurable improvement in patient health outcomes by focusing on high risk, high volume, and problem-prone areas.		Verify the facility's quality improvement (QI) program demonstrates measurable improvements in patient health outcomes through systematic data collection, analysis, and targeted interventions. The program must prioritize high-impact areas, track progress, and validate that changes lead to enhanced clinical results. Evaluating Compliance Review policies of QI program for: Defined metrics for health outcomes (e.g., infection rates, surgical complications, patient satisfaction) Baseline data collection and periodic reassessment to measure progress Action plans for interventions aimed at improving outcomes Methods for analyzing data and validating improvements Alignment with evidence-based practices and regulatory requirements Review QI meeting minutes for evidence of: Discussion of outcome metrics and trends Analysis of data to identify areas for improvement Implementation of interventions and monitoring of their impact Documentation of measurable improvements achieved Interview staff regarding QI goals and specific improvements in patient health outcomes Confirm staff awareness of data-driven changes and their effects on patient care.
10-B-25	A	B	C-M	C	The quality improvement program will improve patient safety by using quality indicators or performance measure(s) by focusing on incidence, prevalence and severity of problems identified.		Verify the facility's quality improvement (QI) program utilizes specific quality indicators and performance measures to systematically monitor, analyze, and improve patient safety. The program must demonstrate measurable enhancements in safety outcomes through data-driven interventions and continuous evaluation. Evaluating Compliance Review policies of QI program for: Defined QI indicators & performance measures for patient safety (e.g., fall rates, medication errors, SSI) Baseline data collection, targets for improvement, and methods for ongoing monitoring Action plans for addressing identified safety risks Processes for validating improvements and sustaining gains Alignment with national standards (e.g., CMS) and evidence-based practices Review QI meeting minutes for evidence of: Regular discussion of QI data and safety performance

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Analysis of trends, root causes of safety issues, and effectiveness of interventions Decisions regarding resource allocation or process changes to address safety gaps Documentation of improvements achieved in patient safety metrics Interview staff to assess: - Understanding of key quality indicators and their relevance to patient safety - Awareness of recent safety improvements and their role in achieving them - Familiarity with reporting mechanisms for safety incidents and near misses.
10-B-26	A	B	C-M	C	The quality improvement program will implement a process to identify and reduce medical errors.		Verify the facility has a structured, proactive process to identify, analyze, and reduce medical errors through its quality improvement (QI) program. This process must prioritize patient safety by systematically addressing errors, near misses, and underlying systemic issues to prevent recurrence. <u>Evaluating Compliance</u> Review policies of QI program for: - Standardized process for reporting medical errors and near misses (e.g., incident reporting system) - Methods for root cause analysis (RCA) or similar methodologies to investigate errors - Action plans for implementing corrective and preventive actions (CAPA) - Metrics to track error rates, trends, and the effectiveness of interventions Review of QI meeting minutes for evidence of: - Discussion of reported errors, near misses, and RCA findings - Development and monitoring of CAPA to address identified issues - Trends in error rates and evaluation of intervention effectiveness - Efforts to foster a culture of safety and continuous improvement Interview staff to assess: - Understanding of the error reporting process and their role in it - Awareness of recent errors, lessons learned, and implemented changes - Confidence in the non-punitive nature of the reporting system.
10-B-27	A	B	C-M	C	The quality improvement program should include patient/service user satisfaction assessment and other performance measures.		Verify the facility's quality improvement (QI) program includes a systematic process for assessing patient satisfaction to identify opportunities for enhancing patient experiences, care delivery, and outcomes. The program must collect, analyze, and act on patient

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							feedback to drive meaningful improvements. <u>Evaluating Compliance</u> Review policies of QI program for: Defined methods for collecting patient feedback Metrics and targets for patient satisfaction Processes for analyzing feedback, identifying trends, and integrating findings into QI initiatives Action plans to address areas of concern Specification for frequency of data collection/reporting Review QI minutes for evidence of: Regular discussion of patient satisfaction data and trends Analysis of feedback to identify root causes of dissatisfaction or areas for improvement Development and implementation of actions to address patient concerns Monitoring of the effectiveness of interventions over time Interview staff to assess: Understanding of patient satisfaction metrics and their importance Awareness of recent patient feedback and related QI actions Involvement in initiatives to improve patient experiences.
10-B-28	A	B	C-M	C	The number and scope of distinct quality improvement projects conducted annually must reflect the scope and complexity of the facility's services and operations.		Verify the facility's annual quality improvement (QI) projects are aligned with the scope, complexity, and risks of the services offered and operations. Projects should address high-priority areas such as patient safety, clinical outcomes, operational efficiency, and regulatory compliance, and should be tailored to the facility's specific services and patient population. <u>Evaluating Compliance</u> Review policies of QI program for: Selection criteria for projects based on facility scope of services, complexity, and risk assessment (e.g., high-volume procedures, high-risk services, patient safety incidents). A documented annual QI plan with specific projects, goals, metrics, and timelines. Processes for prioritizing projects that address critical areas (e.g., infection prevention and control, medication safety, surgical outcomes, and patient satisfaction) Methods for evaluating the effectiveness of QI projects and making adjustments Requirement for annual review and approval of QI projects by leadership or the governing body Review QI meeting minutes for evidence of:

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							Discussion & selection of QI projects based on the facility's services and operational needs Monitoring of project progress, including data collection, analysis, and interim results. Evaluation of project outcomes & decisions for continuation, expansion, or modification of initiatives Integration of QI findings into policies, procedures, and staff training Interview staff regarding: Understanding of the annual QI projects and their relevance to the facility's services Involvement in project implementation and awareness of goals and progress Knowledge of how QI projects impact patient care and operational efficiency.
10-B-29	A	B	C-M	C	Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.		Verify the facility's performance improvement (PI) activities systematically track and address specific, high-priority areas relevant to its scope of services, patient population, and operational risks. These activities must be data-driven, focused on measurable outcomes, and integrated into the facility's daily operations to promote continuous enhancement of care quality and patient safety. <u>Evaluating Compliance</u> Review policies of QI program for: Verify the QI program explicitly defines the specific areas to be tracked (e.g., surgical site infections, medication errors, patient falls, wait times, patient satisfaction) Confirm the program includes: Clear objectives and performance measures for each tracked area Data collection methods and frequency Processes for analyzing data, identifying trends, and implementing corrective actions Responsibilities for staff involved in performance tracking and improvement activities Ensure the program requires regular review and updating of tracked areas based on emerging risks or regulatory changes. Review QI meeting minutes for evidence of: Regular discussion of performance data related to the tracked areas Analysis of trends, root causes of issues, and effectiveness of interventions Decisions regarding resource allocation, policy changes, or staff training to address identified gaps

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Documentation of improvements achieved in the tracked areas Interview staff to assess: - Understanding of the specific areas being tracked and their importance - Awareness of current performance data, goals, and recent improvements - Involvement in data collection, analysis, or improvement initiatives.
Sub-section C: Risk Management							
10-C-1	A	B	C-M	C	As part of an ongoing risk management program, the facility must conduct a risk assessment of its operational activities at least annually. The assessment must study the risks presented to patients and staff by medication management, fall hazards, infection prevention and control, equipment safety, patient risk resulting from long term conditions, and nutrition if any food or beverage services are available to patients. The results of the Risk Assessment must be prioritized for risk mitigation, risk management, and QA/PI (Quality Assessment/Quality Improvement) projects.		Verify the facility conducts an annual, comprehensive risk assessment as part of its ongoing risk management program. This assessment must evaluate risks to patients and staff across critical areas, including medication management, fall hazards, infection prevention and control, equipment safety, patient risks from long-term conditions, and nutrition (if food/beverage services provided). Findings must be prioritized to drive risk mitigation strategies, management actions, and quality assessment/performance improvement (QAPI) projects. <u>Evaluating Compliance</u> Review policies of QI program for: - Requirement for annual risk assessment (RA) of operational activities, with defined scope - Methodologies for risk identification, analysis, and prioritization (e.g., risk matrices, scoring systems) - Mandates to integrate findings into risk mitigation plans and QAPI initiatives Review of annual RA for: - Evaluation of each required area with identified risks, their likelihood, impact, and prioritization levels - Action plans for high-priority risks, including timelines and responsible parties - Linkage to QAPI projects and ongoing monitoring of measures - Risk assessment updated within the past 12 months Review QI meeting minutes and GB documents for evidence of: - Discussion/approval of annual risk assessment - Prioritization of risks and allocation of resources for mitigation - Oversight of QAPI projects derived from assessment findings Interview leadership and risk management staff to assess: - Understanding of the risk assessment process and their roles - Awareness of high-priority risks and corresponding mitigation efforts - Involvement in QAPI projects triggered by the assessment.

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10-C-2	A	B	C-M	C	The facility must develop and maintain a program of risk management, appropriate to the organization. This may be carried out in conjunction with the Quality Assessment/Quality Improvement program (QA/QP).		Verify the facility develops and maintains a comprehensive risk management program tailored to its size, scope of services, and patient population. This program may be integrated with the Quality Assessment/Performance Improvement (QAPI) program but must explicitly focus on identifying, analyzing, and mitigating risks to patients, staff, and the organization. The program shall proactively address clinical, operational, and environmental risks through systematic processes. <u>Evaluating Compliance:</u> Review policies of QI program for: Formal risk management program, defining scope, objectives, and integration with QAPI activities Processes for risk identification (e.g., incident reporting, audits, environmental scans) Methods for risk analysis & prioritization (e.g., risk matrices, severity-frequency charts) Strategies for risk mitigation (e.g., preventive actions, staff training, policy updates) Procedures for monitoring and reviewing effectiveness of risk controls Directive to review risks annually and update as needed Review Risk Management Program to ensure: Documentation of identified risks and their prioritization Action plans for high-priority risks, assigned responsibilities, and timelines Evidence of implemented mitigation measures and their outcomes Records of regular program reviews and updates Integration with QAPI activities (e.g., shared data sources, coordinated improvement projects) Review QI meeting minutes and GB documents for evidence of: Oversight of the risk management program, including regular reviews and approvals Discussion of risk reports, trends, and mitigation progress Decisions linking risk findings to QAPI initiatives and resource allocation Interview leadership and staff regarding: Understanding of the risk management program and their roles within it Awareness of reporting mechanisms for risks and incidents Knowledge of how risk management integrates with QAPI efforts.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
10-C-3	A	B	C-M	C	Near-miss events must be reported, analyzed, and tracked. Measures must be implemented to prevent the event from reoccurring.		Ensure the facility has a structured, non-punitive process for reporting, analyzing, and addressing near-miss events to prevent future incidents and enhance patient safety. The process must include clear reporting mechanisms, thorough analysis, implementation of corrective actions, and ongoing monitoring to ensure effectiveness. <u>Evaluating Compliance:</u> Review policies for: Outline for a non-punitive near-miss reporting process, including: Definitions and examples of near-miss events Confidential reporting mechanisms Steps for analysis (e.g., root cause analysis RCA) Procedures for implementing and monitoring corrective actions Confirmation the policy encourages staff to report without fear of retaliation Review of documentation for near-miss events for: Consistently reported and documented in a centralized system Analysis to identify root causes and contributing factors Tracked to ensure timely resolution and follow-up Evidence of corrective actions Review QI meeting minutes and GB documents for evidence of: Discussion of near-miss trends, analyses, and corrective actions Decisions regarding resource allocation for prevention strategies Oversight of implemented changes and their impact on safety Interview staff regarding: Understanding of what constitutes a near-miss event How and where to report near-misses Knowledge of recent near-miss events and resulting practice changes Confidence in the non-punitive nature of the reporting system.
10-C-4	A	B	C-M	C	A definition of an adverse incident must be documented in policy and procedure, including near miss events.		Verify the facility explicitly defines "adverse incident" and "near miss event" in its policies and procedures to standardize reporting, analysis, and prevention efforts. Clear definitions promote consistent identification, documentation, and response to events that could impact patient safety, fostering a culture of transparency and continuous improvement. <u>Evaluating Compliance:</u> Review policies for: Precise definitions: Adverse event: event that results in unintended harm to a patient Near misses: event that could have resulted in harm but was

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							intercepted or did not impact patient care Confirm policy includes: - Examples of each event type - Reporting procedures for adverse incidents and near misses - Distinctions between events requiring immediate action vs. those for preventive analysis Interview staff regarding: - Understanding difference between adverse incidents and near misses - Awareness of reporting protocols for both event types.
10-C-5	A	B	C-M	C	The facility has processes that report and investigate safety incidents, complaints, adverse events and near misses for patients and staff on a defined basis. The results of these investigations of adverse events are reported in the Quality Improvement/Quality Assessment meetings.		Verify all safety incidents, complaints, adverse events, and near misses are thoroughly investigated, and their results are systematically reported in Quality Assurance Performance Improvement (QAPI) meetings. This process promotes accountability, transparency, and data-driven improvements to enhance safety and care quality. <u>Evaluating Compliance</u> Review policies for: - Directive to immediately report safety incidents, complaints, adverse events, and near misses - Structured investigation processes - Timely reporting of investigation findings to QAPI meetings - Action plans to address identified issues and prevent recurrence - Definition of roles and responsibilities for reporting, investigating, and escalating events Interview staff regarding: - Understanding of reporting procedures for all event types, investigation processes, & their role in them - How event findings are shared in QAPI meetings and evidence of practice changes.
10-C-6	A	B	C-M	C	Adverse events must be tracked and trended on a defined basis.		Verify all adverse events are thoroughly tracked and analyzed, and their results are regularly reported in Quality Assurance Performance Improvement (QAPI) meetings. This process promotes accountability, transparency, and data-driven improvements to enhance safety and care quality. <u>Evaluating Compliance</u> Review policies for: - Mandate to regularly tracking and trend adverse events - Defined intervals for analysis and reporting

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							Use of standardized tools to visualize trends Specified roles for data collection, analysis, and reporting. Directive to escalate significant trends to leadership and QAPI committees Interview staff regarding: - Understanding of how adverse events are reported, tracked, and trended - Awareness of recent trends and their implications for patient safety.
10-C-7	A	B	C-M	C	All staff must be educated in risk management activities on commencement of employment and annually thereafter, and when there is an identified need.		Verify all staff members possess the fundamental knowledge required to identify, report, and mitigate risks within their roles, fostering a consistent and proactive culture of safety and risk awareness throughout the organization. <u>Evaluating Compliance:</u> Review policies for: - Mandate for risk management (RM) education content - Frequency of training (on hire, annual, updates) Interview staff regarding comprehension of RM activities and practical application Review personnel records for evidence of compliance with risk management education: - May include training logs, completion certificates, electronic learning management system records, or performance appraisal notes.
10-C-8	A	B	C-M	C	The facility should have a process to monitor, track and trend patient satisfaction (e.g. surveys or assessments) and implement actions to improve patient satisfaction as necessary.		Verify the facility has a structured, data-driven approach for understanding the patient experience. This process must move beyond simple data collection to include analysis and the implementation of corrective actions aimed at continuous improvement. <u>Evaluating Compliance:</u> Review policies for defined process for the collection, analysis, and response to patient satisfaction data Review documents to confirm analysis of patient satisfaction is ongoing to monitor, track, and identify trends Review QI meeting minutes and GB documents for evidence that: - Patient satisfaction data is reviewed - Decisions are made to implement improvement actions and allocate resources Interview staff and leaders regarding: - Awareness of process to determine patient satisfaction outcomes

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							and recent trends Confirmation that corrective actions (specific changes) are implemented to improve patient experience.
10-C-9	A	B	C-M	C	The facility must conduct an ongoing review of patient complaints and grievances, including defined response times.		Verify the facility has an effective, systematic, and timely process for addressing patient complaints and grievances. This process must be proactive, using reviewed data not just to resolve individual cases but to identify trends and drive systemic improvements in patient care and safety. Evaluating Compliance: Review policies for handling complaints and grievances: Steps to investigate complaints Defined response times for investigation and for formal response Review documents from patient complaint and grievance logs/files for evidence of: Timely and thorough investigation and actions taken Communication with the patient Confirm the resolution was completed within the facility's defined response timeframes Review QI meeting minutes and GB documents for evidence of: Ongoing, aggregate review of complaint data Discussion of trends, patterns, and resulting actions aimed at preventing future occurrences Interview staff regarding knowledge of the process and its outcomes.
10-C-10	A	B	C-M	C	A system is in place for leadership to receive and resolve in a timely manner any ethical dilemmas such as decisions not to treat, to discontinue treatment, or treat against the patient's wishes.		Verify leadership plays an active role in resolving ethical dilemmas. The primary goal is to verify the existence of a defined, accessible, and effective process that ensures ethical dilemmas are escalated to leadership promptly and resolved in a manner that protects patient rights, safety, and well-being. Evaluating Compliance: Review policies for: Procedures for step-by-step system for identifying, reporting, escalating, and resolving ethical dilemmas Defined roles/responsibilities for leadership involvement Defined timeframes for resolution Review any documentation of past ethical dilemmas for evidence of: Timely escalation to leadership Discussions and rationales for final decision and resolution Review QI meeting minutes and GB documents for evidence that ethical dilemmas are received, discussed, and resolved by leadership.

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10-C-11	A	B	C-M	C	A policy should document the competencies of staff handling specialized equipment.		Verify all staff operating specialized equipment have been assessed and documented as proficient, minimizing risk to patient and staff safety and ensuring the equipment is used correctly and effectively. <u>Evaluating Compliance:</u> Review policies for: Process for initial and ongoing competency assessment for staff using all specialized equipment Criteria for determining which equipment requires validated competency Method of competency validation/frequency (e.g., upon hire, annually, after new equipment is introduced) Documentation standards (e.g., training logs, competency assessments in personnel file) Interview clinical staff and managers regarding: Specific pieces of equipment requiring competency validation Reporting process for insufficient competency or if they have not been trained on a new device Review personnel files for evidence of: Competency assessments that align with the policy requirements for each type of equipment used Cross-reference list of specialized equipment with staff competency.
10-C-12	A	B	C-M	C	A system is in effect for documenting, reporting, and follow-up on any patient and family complaints and grievances. Complaints and grievances must be formally addressed at Quality Improvement meetings. The complaints must be addressed by appropriate staff with the patient/family even if no immediate resolution is available.		Verify all patient and family complaints and grievances are captured in a consistent, formal system that guarantees they are documented, investigated, addressed with the patient/family, and used for organizational learning and quality improvement. <u>Evaluating Compliance:</u> Review policies for: Procedures for receiving, documenting, classifying, investigating, and responding to patient/family concerns Required timeframes for responses and escalation Specification of staff roles/responsibilities Mandate to review complaints at QAPI meetings Review complaint logs for evidence of: Documentation of complaints and evidence of investigation Follow-up communication with the patient/family Adherence to defined response timeframes Review QI meeting minutes and GB documents for evidence of complaint data, investigation, resolution Interview staff regarding:

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							Awareness of routine complaint versus formal grievance Reporting mechanisms for complaints.
10-C-13	A	B	C-M	C	The facility must have a written policy to make their complaint process publicly available, via posting within the facility, on the website, by distribution to patients, or through other means that eliminates barriers to patient awareness of such process.		Verify the facility provides clear communication of the complaint process, by posting procedures within the facility, on the website, by distribution to patients, or through other means that eliminate barriers to patient awareness of such process. Evaluating Compliance: Interview staff regarding how the complaint reporting process is disclosed to patients (e.g., clearly posted within the facility, written information given to patients at admission, on the website) Observe the patient admission process to confirm that patients are made aware Inspect waiting areas for evidence of postings (if applicable).
Sub-section D: Peer Review							
10-D-4	A	B	C-M	C	Peer review and the associated peer review meetings include at a minimum the same random cases and adverse events submitted to the Patient Safety Data Reporting since the preceding peer review meeting.		Verify peer review activities are comprehensive and aligned with external reporting obligations by mandating that all cases submitted for Patient Safety Data Reporting (random and adverse events) are also included in the internal peer review process. This creates a closed-loop system where data used for external transparency is also rigorously analyzed internally for quality improvement. Evaluating Compliance: Review of policies for requirement that: All cases submitted for PSDR (random selections, all adverse events) are included in peer review process Review QI meeting minutes and GB documents for evidence of an active process: Evidence that the required cases were discussed and analyzed Any resulting actions were documented Cross-reference audit: Obtain logs of cases submitted for Patient Safety Data Reporting since the last peer review meeting Confirm each reported case was indeed reviewed by the peer review committee or designated reviewer Interview the Medical Director, Quality coordinator, and peer review members regarding: Link between PSDR and active internal peer review Process for ensuring cases submitted for PSDR are captured for internal peer review.

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
10-D-12	A	B	C-M	C	To be compliant, a copy of a Business Agreement must be signed by each physician working outside the facility participating in peer review, and a copy must be retained on file in the facility.		To ensure all external physicians participating in the facility's peer review process are legally bound by a Business Agreement (BA) that defines the terms of their engagement, protects confidential information, and formalizes their role in quality improvement activities. This safeguards the integrity of the peer review process and ensures compliance with contractual and regulatory obligations. <u>Evaluating Compliance:</u> Review policies for: Procedures related to peer review and contractor agreements Mandate the execution of a BA with external peer reviewers prior to their participation in activities Specify record retention requirements. Review documents to ensure compliant external peer review process: Master BA document contains essential elements, such as: scope of services, confidentiality clauses, terms, and data protection provisions. Obtain a list of all external physicians who've participated in peer review: Audit individual files to confirm a BA is dated/signed prior to involvement in peer review activities Interview the Medical Director, Quality/Compliance coordinator, Administrative Director, or individual responsible for managing peer review to assess their understanding/requirement for a BA with external peer reviewers.
10-D-13	A	B	C-M	C	If peer review sources external to the facility are used to evaluate the delivery of medical care, an agreement to conduct peer review is so written as to waive the confidentiality of the clinical records.		Verify, that when external entities or individuals are engaged to perform peer review, a formal agreement is in place that explicitly permits the sharing of confidential patient health information (PHI) for the purpose of quality review. <u>Evaluating Compliance:</u> Review policies for: Process for engaging external reviewers Mandates the use of an agreement containing confidentiality waiver Requires the agreement to be fully executed prior to any review of clinical records Review language in external peer review agreement for specific contractual language: Waiving confidentiality for clinical records solely for the purposes of conducting the peer review activity Precise, unambiguous, and compliant with applicable privacy laws Review documents for external peer review to ensure:

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							Fully executed agreement containing the explicit confidentiality waiver is on file Date of agreement/signature precedes the date of record sharing Interview staff and leadership regarding: Legal and regulatory necessity for the confidentiality waiver for external peer review Ability to articulate the process for ensuring the correct agreement is on file before access to clinical records.
10-D-14	A	B	C-M	C	Peer review may be done by a recognized peer review organization or a physician, podiatrist, or oral and maxillofacial surgeon other than the operating surgeon.		Verify peer review is conducted objectively by a qualified, independent entity or individual who is not the operating surgeon, thereby promoting impartial evaluation, minimizing bias, and fostering meaningful quality improvement. <u>Evaluating Compliance:</u> Review policies for: Procedures defining who is authorized to perform reviews Alignment with any state-specific regulatory exceptions Review documents for peer reviewer credentials and ensure reviewers are authorized: Physician from a recognized external organization -OR- A physician, podiatrist, or oral and maxillofacial surgeon with appropriate credentials who was not the operating surgeon for the case(s) being reviewed Review documents of peer review records to ensure they: Include all required elements as defined by facility policy Demonstrate a thorough, objective evaluation Review QI meeting minutes and GB documents for evidence of: Process for selecting reviewers ensures independence and objectivity. Peer review findings are reviewed Interview the Medical Director, Quality coordinator, and participating peer reviewers regarding how reviewers: Are selected (recognized external organization, internal independent peer reviewer) Maintain their independence from the cases they review.
10-D-15	A	B	C-M	C	Peer review is conducted and contains, at a minimum, the following review of each clinical record subject to peer review: · Adequacy and legibility of history and physical exam · Adequacy of the surgical consent		Verify peer review is a structured, comprehensive process that evaluates critical aspects of clinical care documentation. The goal is to ensure that patient records meet established standards for completeness, accuracy, and legal/clinical appropriateness. <u>Evaluating Compliance:</u>

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					· Adequacy of appropriate laboratory, EKG, and radiographic reports · Adequacy of a written operative report · Adequacy of anesthesia and recovery records (with IV sedation or general anesthesia) · Adequacy of instructions for post-operative care · Documentation of the discussion of any complications		Review policies for: - Directive to evaluate all clinical records reviewed for the seven elements listed in the standard - Definition of objective criteria for "adequacy" Review documents of peer review records to ensure they: - Each record includes documentation for all seven required elements - Check for evidence of critical assessment rather than passive acknowledgment (notes, comments) - Cross-check a sample reviewed cases with clinical records to ensure findings align with documentation Review peer review committee meeting minutes to ensure: - Discussions address deficiencies (or exceptions) related to the seven elements - Corrective actions are documented Interview the Medical Director, Quality coordinator, and participating peer reviewers regarding: - Seven elements required for review and the criteria for "adequacy" in each category - How peer review findings are used to improve documentation practices.

SECTION 11: PERSONNEL

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Sub-section A: Personnel							
11-A-2	A	B	C-M	C	All personnel are provided with a code of ethics or behavior that governs their conduct when communicating with fellow staff or the public.		Verify every member of staff is formally introduced to a clear set of behavioral expectations, promoting a respectful, professional, and ethical workplace culture. The goal is to proactively define and prevent misconduct in all communications, thereby protecting staff well-being, patient satisfaction, and the organization's reputation. <u>Evaluating Compliance:</u> Review policies for: Facility's official "Code of Conduct" or "Code of Ethics" Addressing expected behaviors in internal and external communications Interview staff to assess regarding their understanding of: Facility's Code of Ethics/Conduct and its application Key behavioral expectations, especially related to respectful communication with colleagues and patients Reporting process for observed violations Review training curricula to confirm content on the Code of Conduct Review personnel files for evidence that each individual has received, understood, and agreed to abide by the Code of Conduct.
Sub-section B: Medical Director & Facility Director							
11-B-7	A	B	C-M	C	The Facility Director must be actively involved in the direction and management of the facility.		Verify the Facility Director is substantively engaged in the operational, clinical, and strategic leadership of the facility, providing consistent oversight and accountability. <u>Evaluating Compliance:</u> Review documents to determine Facility Director's active involvement: Confirm job description, appointment letter, and place in organizational chart align with defined responsibilities for direction and management Ensure QAPI, Governing Body, Medical Executive, and other leadership meetings minutes provide evidence of the Facility Director's regular participation, participation, and decision-making Evaluate reports, policies, and strategic plans developed or approved by the Facility Director, for proof of involvement in key operational areas (e.g., budget management, staffing, policy

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							implementation, and regulatory compliance) Interview the Facility Director's regarding specific roles, current strategic initiatives, and operational challenges Interview staff regarding the Facility Director's visible presence, accessibility, and authority in daily operations.
11-B-8	A	B	C-M	C	The Facility Director is responsible for establishing and enforcing policies that protect patients. The Facility Director monitors medical and facility staff members for compliance with this policy.		Verify the Facility Director executes their leadership responsibility by actively overseeing and verifying that all staff adhere to established policies, thereby maintaining consistent operational standards, promoting a culture of accountability, and ensuring continuous regulatory compliance. <u>Evaluating Compliance:</u> Review specific policy in question to confirm it: Explicitly assigns the monitoring responsibility to the Facility Director Outlines methods for this oversight Review documents demonstrating active monitoring by the Facility Director's, including: Compliance audits Meeting minutes where monitoring data was presented and reviewed Logs of corrective actions initiated Performance evaluations that include policy adherence metrics QAPI or leadership meeting minutes to confirm: Facility Director's monitoring activities lead to concrete actions, policy revisions, or staff education Interview staff regarding: Awareness of policy requirements and understanding that Facility Director is responsible for compliance Corroboration that monitoring and feedback routinely occur Confirm the Facility Director's ability to describe their specific monitoring process for this policy, including the frequency, methods, and recent findings.
11-B-10	A	B	C-M	C	The Medical Director must be involved in planning and budgeting for the facility's range of services.		Verify the Medical Director provides essential clinical input into strategic resource allocation, aligning financial planning with patient safety and quality care delivery. <u>Evaluating Compliance:</u> Review documents for evidence of Medical Director (Med Dir) participation in facility operations, including: Strategic plans for developing budgets (equipment procurement,

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							staffing) Governing Body meeting minutes (discussions on service expansion) Interview administrative leadership to assess the Director's involvement in the planning process Confirm that administrative leaders recognize this contribution Interview the Medical Director regarding how clinical needs inform budgetary decisions.
11-B-11	A	B	C-M	C	The Medical Director signs an Attestation that the direction and management of the facility is under his/her management.		Verify the Medical Director has formally accepted of legal and operational responsibility for the facility's clinical direction and management. <u>Evaluating Compliance:</u> Review the attestation form in the Medical Director's file to confirm: It is signed, dated, and specific to their management role The attestation's language matches governing body requirements Interview the Medical Director regarding their acceptance of direct responsibility for the facility's management and clinical direction.
11-B-12	A	B	C-M	C	The Medical Director must ensure that the facility meets all local, regional and country regulations including those relating to employment health and safety, building, environmental protection, reportable diseases, and waste management.		Verify the Medical Director is held accountable for the facility's comprehensive regulatory compliance, ensuring a safe, lawful, and ethically operated environment for patients and staff. <u>Evaluating Compliance:</u> Review policies, audit reports, and inspection certificates (e.g., fire safety, biomedical waste, OSHA) to: Verify compliance with applicable regulations Review meeting minutes to confirm the Medical Director's participation in action plans for regulatory issues Confirm the Medical Director's job description includes oversight for regulatory compliance.
11-B-13	A	B	C-M	C	The Medical Director shall document the strategic plan for the facility.		Verify the Medical Director provides direct leadership in establishing the facility's clinical and operational goals, driving continuous quality improvement and strategic growth. <u>Evaluating Compliance:</u> Review administrative and governance policies for: Process for developing and documenting the strategic plan Mandate for approval by the Medical Director Review strategic plan document for Medical Director approval (signed, dated) Review Quality Assurance/Performance Improvement and leadership

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
							meeting minutes for: Evidence the strategic plan is actively used to guide decisions, resource allocation, and initiative planning Interview the Medical Director regarding their personal role in developing strategic plan and its key objectives.
11-B-14	A	B	C-M	C	The Medical Director should document the staffing levels and what qualifications are required for each position based on the services offered at the facility.		Verify the facility's staffing model is formally documented and rationally designed, with personnel qualifications directly matched to the clinical services provided, thereby ensuring patient safety and quality of care. Evaluating Compliance: Review the facility's written staffing plan to verify documentation of: Required positions, staffing levels, and specific qualifications for each role (e.g., licenses, certifications) Cross-reference the staffing plan with the facility's list of offered services to confirm alignment Interview the Medical Director regarding involvement in and understanding of the staffing plan Confirm hiring managers understand and implement these documented requirements.
11-B-15	A	B	C-M	C	The Medical Director must annually review credentialing and performance for all practitioners, staff and volunteers annually, including contract employees.		Verify the Medical Director provides active oversight of the competency and performance of all individuals within the facility, ensuring they are qualified to deliver safe and effective patient care. Evaluating Compliance: Review policies regarding credentialing and performance evaluation to confirm a requirement for: Medical Director review for all personnel categories (practitioners, staff, volunteers, contractors) At least annually Review Governing Body meeting minutes for evidence of: Discussions of annual review process Outcomes from the review Interview the Medical Director and HR/Credentialing Manager regarding the annual review process, including: Any differences in performance reviews for employees versus contractors Examples of any recent actions taken Review personnel and credentialing files for evidence of the Medical Director's annual review and approval (e.g., signed forms, dated checklists, electronic approvals).

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11-B-16	A	B	C-M	C	The Medical Director should review and maintain a record of the performance of all practitioners, staff and volunteers at least annually, including contract employees. This should include a record of corrective actions and educational activities.		Verify the Medical Director actively oversees and documents the ongoing competency and performance of all personnel to maintain quality care standards. Evaluating Compliance: Interview the Medical Director's regarding: Annual review process Examples of corrective actions implemented Confirm HR staff can demonstrate the Medical Director's active participation in the review system Review personnel files for evidence of annual performance review, including: Educational activities Corrective actions Medical Director's review and approval.
11-B-17	A	B	C-M	C	Each personnel file has evidence of general facility-specific orientation and training related to the individual's job duties.		Verify the facility provides all staff with facility orientation (e.g., safety protocols, patient rights, medical record security) and position-specific training (e.g., steam sterilization, environmental cleaning) to minimize risk to staff, ensure regulatory compliance, and improve patient safety and operational efficiency. Evaluating Compliance: Review policies for training requirements, including: Directive to provide facility orientation and position-specific training Specifying generalized orientation content (for all staff, contractors, and physicians) Interview leadership regarding: How/when is general orientation administered What material is reviewed with all staff (e.g., policies, safety protocols, patient rights) How position-specific training is administered (e.g., in-services, via preceptor) Review personnel records for evidence of: Training (initial/annual/updates for new facility policies) Competency validation for position-specific tasks (when applicable).
Sub-section C: Surgeons/Proceduralists/Etc.							
11-C-2	A	B	C-M	C	Procedures must be performed in a safe manner by qualified physicians, advanced practice registered nurses, physician assistants, or other licensed healthcare professionals who have been granted clinical privileges by		Verify all procedures are performed safely by healthcare practitioners who are properly credentialed, privileged, and working within their legally authorized scope of practice.

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					the governing body in accordance within their scope of practice, state law, and approved policies and procedures of the facility.		<u>Evaluating Compliance:</u> Review policies for credentialing/privileging healthcare practitioners for: Who is authorized to perform surgery/procedures (e.g., physicians, APRN, PA) Process for credentialing/re-credentialing (verifying qualifications, status to practice legally) Process for granting privileges (approval by governing body (GB) setting scope of practice) Mandate that practitioners must practice within their delineated scope Interview schedulers regarding steps to ensure procedures align with delineation of privileges Review credentialing files for evidence of GB-approved delineation of clinical privileges Cross-check operative log with credentialing files to confirm cases by only privileged practitioners.
11-C-6	A	B	C-M	C	The facility must have written policies and procedures that address the criteria for clinical staff privileges and the process that the facility's leadership body uses when reviewing physician, APRN, PA, and other licensed healthcare professional credentials and determining whether to grant privileges and the scope of the privileges for each practitioner.		Verify every practitioner who performs surgery or procedures in the facility, including those directly employed or under contract, has been determined qualified and granted privileges for the specific procedures she/he performs in the facility. The facility's governing body is responsible for reviewing the qualifications of all healthcare practitioners and granting privileges as appropriate. <u>Evaluating Compliance:</u> Review policies for credentialing/privileging healthcare practitioners for: Who is authorized to perform surgery/procedures (e.g., physicians, APRN, PA) Process for credentialing/re-credentialing (verifying qualifications, status to practice legally) Process for granting privileges (approval by governing body, setting scope of practice) Mandate that practitioners must practice within their delineated scope Interview credentialing leadership regarding the verification/privileging process and enforcement Review credentialing files for evidence of: Primary-source verification of credentials GB-approved scope of practice (delineation of privileges) Cross-check clinical records/operative log with credentialing files to confirm practitioners function within approved scope.

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11-C-8	A	B	C-M	C	Members of the medical staff, including both directly employed and contract medical staff, must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The facility grants privileges in accordance with recommendations from qualified medical/dental personnel.		Verify all members of the medical staff undergo a thorough credentialing process (including review of education, training, licensure, certifications, experience, and disciplinary history) to ensure professional qualification and competence and meet regulatory and accreditation requirements. Evaluating Compliance: Review policies for credentialing/privileging healthcare practitioners for: Who is authorized to perform surgery/procedures (e.g., physicians, APRN, PA) Process for credentialing/re-credentialing (verifying qualifications, status to practice legally) Process for granting privileges (approval by governing body, setting scope of practice) Mandate that practitioners must practice within their delineated scope Review Governing Body meeting minutes for evidence of: Discussions and review of candidate qualifications (initial credentialing, during re-credentialing) Outcomes (approvals, denials) Interview credentialing leadership regarding the credentialing/privileging process Review credentialing files to verify medical staff have been granted clinical privileges. Minimum documentation includes: Primary-source verification of credentials Country/State licensure, registration, or state certification (as applicable) Certification by a specialty organization (as appropriate) Other training or pertinent experience Recommendation by qualified medical/dental peers (concerning practitioner's competence) Scope of privileges granted to the practitioner by the Governing Body (delineation of privileges) Rational for any privileges granted against peer recommendation (when applicable) Confirm re-credentialing is performed at least every three (3) years.
11-C-20	A	B	C-M	C	The practitioners shall be required to show evidence of hospital privileges including scope of practice relevant to the procedures performed in the facility.		Verify the scope of privileges granted to practitioners aligns with current hospital privileges, to ensure professional qualification and competence. Evaluating Compliance:

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							Review policies for credentialing/privileging healthcare practitioners for: - Process for credentialing/re-credentialing (verifying qualifications, status to practice legally) - Requirement that practitioners have hospital privileges for the procedures requested - Process for granting privileges (approval by governing body, setting scope of practice) - Mandate that practitioners must practice within their delineated scope Review Governing Body meeting minutes for evidence of: - Discussions and review of candidate qualifications (initial credentialing, during re-credentialing) - Outcomes (approvals, denials) Interview credentialing leadership regarding validation of hospital privileges Review credentialing files for evidence of: - Current hospital privileges for the procedures requested by the practitioner - Scope of privileges granted to the practitioner by the Governing Body (delineation of privileges) Confirm hospital and facility privileges align.
Sub-section D: Anesthesia Providers							
11-D-3			C-M	C	An anesthesia professional must be responsible for the administration of dissociative anesthesia with propofol, spinal or epidural blocks, or general anesthesia as well as the monitoring of all life support systems.		Verify only qualified anesthesia professionals administer high-risk medications and perform high-risk anesthesia techniques, whilst providing continuous monitoring to ensure patient safety. <u>Evaluating Compliance:</u> Review policies for: - Mandate that only authorized anesthesia staff (e.g., physician, CRNA, CAA) may perform: - Dissociative anesthesia with propofol, neuraxial blocks, and general anesthesia - Monitoring requirements - Documentation standards Interview staff regarding facility protocols for anesthesia administration Observe practice to confirm use of anesthesia professionals & continuous monitoring Review clinical records for evidence of: - Type of anesthesia and/or technique - Continuous monitoring (oxygenation, ventilation, circulation, body

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							temperature) Anesthesia professional (name, credentials).
11-D-6		B	C-M	C	If responsible for supervising anesthesia or providing anesthesia, the qualified physician must be present in the operating suite throughout the administration of anesthesia.		Verify the continuous presence of a physician in the operating room, when responsible for administering anesthesia or supervising anesthesia administration, to meet the patient's medical needs in case of an emergency. <u>Evaluating Compliance:</u> Review policies for: Alignment with any state law regarding supervision of anesthesia services Process for credentialing (verifying qualifications, status to practice legally) Mandate that supervising physicians must be qualified to do so Mandate that practitioners must practice within their delineated scope Review Governing Body meeting minutes for evidence of: Discussions and review of candidate qualifications Outcomes (approvals, denials) and delineation of privileges (including supervision) Interview staff regarding protocols for physicians providing/supervising anesthesia care Observe practice to validate continuous presence of supervisor Review clinical records for evidence of: Name of person administering anesthesia (name, credentials) Documentation of physician supervisor Review credentialing files for evidence of: Physician scope of privileges includes supervision of anesthesia administration
11-D-21	A	B	C-M	C	The qualified individual responsible for supervising the administration of anesthesia must have knowledge of anesthetics and resuscitative techniques appropriate for the type of anesthesia being administered.		Verify all staff, responsible for supervising the patient during anesthesia delivery, are competent to detect variances in patient stability and meet the patient's medical needs in case of an emergency. <u>Evaluating Compliance:</u> Review policies for: Alignment with any state or country law regarding supervision of anesthesia services Process for credentialing (verifying qualifications, status to practice legally) Mandate that supervising physicians must be qualified to do so

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							Mandate that practitioners must practice within their delineated scope Review Governing Body meeting minutes for evidence of: - Discussions and review of candidate qualifications - Outcomes (approvals, denials) and delineation of privileges (including supervision) Interview staff regarding protocols for physicians providing/supervising anesthesia care Observe practice to validate continuous presence of supervisor Review clinical records for evidence of: - Name of person administering anesthesia (name, credentials) - Documentation of physician supervisor (name, credentials) Review credentialing files for evidence of: - Physician scope of privileges includes supervision of anesthesia administration - Current ACLS certificate (must include skills verification).
Sub-section E: Facility Staffing							
11-E-1	B	C-M	C		When a patient is present in the facility to undergo a procedure under a higher level of anesthesia than meets the QUAD A definition of Class A, there is a licensed registered nurse, physician other than the operating surgeon, or physician's assistant designated as the person responsible for patient care in all areas of the facility (i.e. operating room, operating suite, and all patient care areas), in accordance with state/local law.		Verify a qualified staff member is in charge of patient care in all areas of the facility. The responsible person must be immediately available to respond to staff needs and patient emergencies. Qualified candidates include licensed Registered Nurses, Physician (other than the operating surgeon/proceduralist), or a Physician Assistant, in accordance with state/local law. Licensed practical nurses and medical assistants do not meet this requirement, as both require supervision by a physician or RN. <u>Evaluating Compliance:</u> Review policies for: - Appointment of a person in charge (when procedures scheduled > Class A anesthesia) - Qualified candidates (e.g., RN, physician (other than operating), PA) - Definition of "immediately available" - Responsibilities for person in charge Review surgery schedules or shift reports for evidence of compliance Interview staff regarding determining who is in charge and charge responsibilities Verify compliance by cross-checking operative logs, clinical records, and staffing schedules.

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11-E-7		B	C-M	C	A dentist employing or using general anesthesia or deep sedation shall maintain a properly equipped facility for the administration of general anesthesia, staffed with supervised assistant/dental hygienist personnel capable of reasonably handling procedures, problems, and emergencies.		Verify patient safety standards are met when general anesthesia or deep sedation is administered. The facility must define "properly equipped" to identify the equipment, supplies, medications, and resource material (e.g. ACLS algorithms) required for use when providing anesthesia and in emergencies. Evaluating Compliance: Review policies for definitions of: Staffing requirements when general anesthesia (GA) or deep sedation (DS) is administered Definition of "properly equipped" Review daily checklists for evidence that essential equipment/supplies are maintained Interview staff regarding routing staffing for GA and DS cases Observe practice to confirm staffing conforms with policy requirements Inspect facility equipment for: Essential equipment/supplies are present and functional Inventory of supplies/medications is adequate for facility volume (not expired) Review personnel files of supervised assistants and dental hygienist for evidence of: Training regarding anesthesia/sedation safety (initial, annual) Validated competency (for procedures, emergencies) (initial, ongoing per facility policy) Current BLS certification
Sub-section G: Post-Anesthesia Care Unit (PACU) Staffing							
11-G-1		B	C-M	C	There is a written policy that whenever parenteral sedation, dissociative drugs, epidural, spinal or general anesthesia is administered, a physician is immediately available until the patient is discharged from the PACU.		Verify a physician is immediately available to respond to patients' needs during post-anesthesia care. Immediately available means the physician is available and accessible within the facility to provide patient care and respond to emergencies without delay. Evaluating Compliance: Review policies for: Mandate of physician being immediately available until patient is discharged from the PACU Definition of "immediately available" Interview staff to determine when the physician may leave the premises Observe practice to confirm the physician is accessible to staff

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							Review clinical records for evidence of the physician's discharge signature and timestamp.
11-G-2		B	C-M	C	All recovering patients must be observed and supervised by trained medical personnel in the PACU. A physician, CRNA, PA, or RN currently licensed and certified in advanced cardiac life support (ACLS) or pediatric advanced life support (PALS), as appropriate, is immediately available until the patient has met PACU discharge criteria for discharge from the facility. Local mandates and stricter standards may apply.		Verify a qualified and trained medical staff member is immediately available to ensure the safe recovery of patients in the PACU. The Physician, CRNA, RN, NP, or PA in charge of recovering the patient is responsible for all PACU documentation in the clinical record. LPNs, LVNs, and Medical Assistants are not qualified to recover patients, as all require direct supervision by a physician, CRNA, RN, NP, or PA. Note: If a contract anesthesiologist brings emergency medications or equipment into the facility and removes them when leaving, the contract anesthesiologist must remain in the facility until all patients have been discharged from the PACU. <u>Evaluating Compliance:</u> Review policies for: Alignment with any local or state mandates for staffing (when additional/stricter requirements apply) Mandate that qualified, trained staff is immediately available until patient is discharged from the PACU Definition of "immediately available" Interview staff to determine: PACU protocols If emergency equipment/medications are supplied by contracted anesthesia professionals Observe practice to confirm a physician, CRNA, RN, NP, or PA is immediately available Review personnel records for evidence of current ACLS and/or PALS certification for all PACU staff Review clinical records for evidence of the physician's discharge signature and timestamp
11-G-5		B	C-M	C	A minimum of one ACLS, and when appropriate PALS as well, certified staff member must be present in the facility until all patients recovering from anesthesia have met the facility's discharge criteria for discharge from the facility.		Verify all recovering patients are observed and monitored until discharge criteria have been met as determined by qualified personnel. Note: If a contracted anesthesia professional brings any emergency medications or equipment into the facility and removes any of these items when leaving the facility, the contractor must remain in the facility until all patients have been discharged from the PACU. <u>Evaluating Compliance:</u>

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							Review policies for: Mandate: ≥ one (1) ACLS (and/or PALS) certified staff member is present until patients meet discharge criteria Interview staff regarding use of equipment/medicines from contractors, staffing minimums, & discharge process Observe practice to confirm compliance Review personnel files for evidence of current ACLS and/or PALS (separate BLS certificate not required)
11-G-7	B	C-M	C		All recovering patients must remain under direct observation and supervision by appropriate medical personnel who are trained in the assessment of patient vital signs, post-operative care, and safety matters until discharged from monitored patient care.		Verify a qualified, trained medical staff member is immediately available to ensure the safe recovery of patients after procedures, thus permitting safe discharge. The facility must define "appropriate medical personnel" and related training requirements in its policies. Note: If a contracted anesthesia professional brings emergency medications or equipment into the facility and removes them when leaving, the contractor must remain in the facility until all patients have been discharged from the PACU. <u>Evaluating Compliance:</u> Review policies for: Definition of which "appropriate medical personnel" by position type and qualifications required Mandate: ≥ one (1) ACLS (and/or PALS) certified staff member is present until patients meet discharge criteria Interview staff regarding use of equipment/medicines from contractors, staffing minimums, & discharge process Observe practice to confirm compliance Review personnel files for evidence of current ACLS and/or PALS (separate BLS certificate not required)
Sub-section H: Personnel Records							
11-H-2	A	B	C-M	C	The facility maintains a manual outlining personnel policies that is reviewed annually and updated as needed.		Verify the facility has clearly defined policies in place to ensure all employees are aware of expectations on behavior within the workplace environment. This includes references to areas such as dress code, attendance requirements, vacation time allotment, and acceptable use of technology. The facility must provide training during staff onboarding and when policies are updated. <u>Evaluating Compliance:</u> Review policies for inclusion of comprehensive personnel policies Interview staff regarding:

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							Knowledge of essential policies Where policies can be accessed Review personnel files for evidence of training (initial, with updates)
11-H-4	A	B	C-M	C	The facility maintains a personnel file for all clinical and administrative employees, including direct and contract employees.		Verify the facility maintains comprehensive personnel files for all clinical and administrative staff to ensure compliance with federal, state, and accreditation standards, protect against liability, and ensure patient safety. All staff providing care or services within the facility, whether employees or contractors, must have a file onsite. This includes surgeons, anesthesia professionals, PAs, RNs, LPNs, medical assistants, scrub techs, sterile processing techs, lab and x-ray techs, other clinical employees, and administrative staff. Note: General staff information such as previous employment, disabilities, employment, and performance reviews are protected. However, access must be provided for the surveyor to confirm a comprehensive file is kept for all staff and to evaluate facility compliance with state regulations, federal regulations and QUAD A standards (e.g., immunizations, annual health questionnaire, and, safety training). Evaluating Compliance: Interview human resources manager regarding process for ensuring file content is up to date Request a list of all staff (employees and contractors) Confirm personnel files are maintained for all staff.
11-H-5	A	B	C-M	C	Each personnel record contains any health problems of the individual which may be hazardous to the employee, other employees or patients, and a plan of action or special precautions delineated as needed. To be reviewed and updated annually.		Verify the facility maintains documentation of the current health status of all staff, that informs the facility of any health conditions that may potentially put other staff or patients at risk. If no hazardous health problems exist, this should be documented in the personnel file. This must be updated and reviewed annually Note: The process must be in accordance with ADA requirements (§12112(d)). Information cannot be obtained until after an offer of employment has been made. However, a facility may make pre-employment inquiries into an applicant's ability to perform job-related functions. Evaluating Compliance: Review personnel files for evidence of: A health status questionnaire (at least annually) Special precautions or plan of action when health problem has been identified (when applicable).

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11-H-6	A	B	C-M	C	Each personnel record contains resume of training and experience.		Verify the personnel file includes documentation of past training and work experiences to ensure staff are qualified to perform their duties. The file must also include evidence of any specialized training (i.e. administering moderate sedation) required for the position. <u>Evaluating Compliance:</u> Review personnel files for evidence of: Job application (for non-clinical staff) Resume or CV Specialized training certificates (or certifications) Confirm evidence of specialized training when essential to the position.
11-H-8	A	B	C-M	C	Each personnel record contains date of employment.		Verify the personnel file includes documentation of the employee's date of hire (or the date a contracted staff member begins working in the facility). This date assists with determining compliance with standards requiring annual review or training. <u>Evaluating Compliance:</u> Review personnel files for evidence of date of hire (or contract commencement).
11-H-9	A	B	C-M	C	Each personnel record contains description of duties.		Verify the personnel file includes documentation of the duties required for the position. The scope of approved privileges shall constitute the clinical job description for a healthcare practitioner (e.g., Surgeon, Anesthesiologist, CRNA). When any clinical position includes non-patient care duties (e.g., peer review, participation in infection prevention and control or quality programs), this should be documented. Facility appointments (e.g., Medical Director and Facility Director) must have a comprehensive job description. <u>Evaluating Compliance:</u> Review personnel files for evidence of job descriptions for: Non-clinical positions (e.g., billing manager, receptionist) Clinical positions (e.g., RN, scrub tech) Facility appointments (e.g., Medical Director, Infection Preventionist).
11-H-10	A	B	C-M	C	Each personnel record contains on-going records of inoculations or refusals in accordance with local, state/provincial or federal/national requirements.		Verify the personnel file includes documentation of any mandatory vaccine administration, which may vary from state to state. The facility must confirm the requirements for the state (where the facility is located) and determine the acceptable documentation for proof of vaccination.

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							<u>Evaluating Compliance:</u> Review policies for: - Alignment with state-specific requirements for vaccinations - Alignment with state-specific requirements for Tb screening/testing - Acceptable vaccine records (documented injections, vaccine registry records, titer level, declination) Review personnel files for evidence of vaccination administration or refusal.
11-H-12	A	B	C-M	C	Each personnel record contains current certification or license if required by the state, province, region, or country.		Verify the personnel file includes documentation of current certification or license (when required) to verify qualifications, maintain compliance with state, province, regional or country regulations, and ensure patient safety. <u>Evaluating Compliance:</u> Interview human resources manager regarding process for verifying professional license is current Review personnel files for evidence of license and certifications (not expired).
11-H-13		B	C-M	C	The practitioners shall document an appropriate level of Continuing Medical Education (CME) and follow nationally accepted evidence-based protocols where they exist.		Verify the personnel file includes documentation of required continuing medical education (CME) for healthcare practitioners, to stay current with nationally recognized evidence-based guidelines and improve patient outcomes. Minimum hours of education must follow state or country requirements. <u>Evaluating Compliance:</u> Review personnel files for evidence of CME documentation for healthcare practitioners.
Sub-section I: Personnel Training							
11-I-1	A	B	C-M	C	Each personnel record has evidence of annual hazard safety training.		Verify the personnel file includes documentation that annual hazard safety training is administered, to keep staff knowledge of safety protocols current and ensure compliance with federal regulations. Staff must understand the hazards they are likely to encounter and how to identify each one. Control training ensures that they know what to do when encountering biological, chemical, physical, safety, or psychosocial hazards Online training courses using a learning management system are acceptable when the content is reviewed/approved by the facility annually. However, the facility must provide additional training regarding action to be taken in the event of exposure (specific to their

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							facility). Non-specific, general online training is not acceptable. <u>Evaluating Compliance:</u> Review personnel files for evidence of annual hazard safety training for all staff Confirm the content is facility specific and covers action plans when hazards are encountered.
11-I-2	A	B	C-M	C	Each personnel record has evidence of annual blood borne pathogen training.		Verify the personnel file includes documentation that annual blood borne pathogen (BBP) training is administered to staff with a reasonable risk of exposure to blood or bodily fluids, to minimize exposure risk and ensure compliance with federal regulations. BBP training ensures that clinical staff can identify the risks of exposure, prevent exposure by taking proper precautions, and take effective action in the event of exposure Online training courses are acceptable when the content is reviewed/approved by the facility annually. However, the facility must provide additional training regarding action to be taken in the event of exposure (specific to their facility). Non-specific, general online training is not acceptable. <u>Evaluating Compliance:</u> Review personnel files for evidence of annual blood borne pathogen training for all clinical staff Confirm the content is facility specific and covers action plans for exposures.
11-I-3	A	B	C-M	C	Each personnel record has evidence of annual standard precaution training.		Verify the personnel file includes documentation that annual standard precaution training is administered to all clinical staff to prevent the transmission of infectious diseases in healthcare settings and ensure compliance with federal/national regulations. Online training courses are acceptable when the content is reviewed/approved by the facility annually. <u>Evaluating Compliance:</u> Review personnel files for evidence of annual standard precaution training for all clinical staff.
11-I-4	A	B	C-M	C	Each personnel record has evidence of other annual safety training including operative fire safety training and structure fire safety, including operation of a fire extinguisher.		Verify the personnel file includes documentation that annual fire safety training is administered to all staff to prevent, respond to, and evacuate themselves and others from fires safely. This training must be facility specific. Online training is not sufficient.

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							<u>Evaluating Compliance:</u> Review training materials to ensure content is comprehensive for a healthcare facility, at a minimum including: Use of fire extinguishers Extinguishing fires on the surgical field (as applicable) Evacuation of patients requiring mobility assistance Evacuation plans for sedated or anesthetized patients (as applicable) Review personnel files for evidence of annual fire safety training for all staff.
11-I-5	A	B	C-M	C	Each personnel record has evidence of at least Basic Cardiopulmonary Life Support (BLS) certification, but preferably Advanced Cardiac Life Support (ACLS) and/or Pediatric Advanced Life Support (PALS) for each operating room and PACU team member, depending on the patient population served.		Verify the personnel file includes documentation of current certification to respond to cardiopulmonary emergencies for all clinical staff. ACLS (and/or PALS) certification is preferable to BLS. Online training is not sufficient BLS certification (initial, ongoing) must be intended for healthcare professionals (not lay people) and include a didactic component <u>and</u> a hands-on skills check ACLS (and/or PALS) certification (initial, ongoing) must be obtained from the American Heart Association (or equivalent) that includes a didactic component <u>and</u> a hands-on skills demonstration of airway management and automated external defibrillator (AED) use Perioperative Life Support (PerLS) (along with current BLS) may be accepted for all perioperative physicians and members of the surgical team including Anesthesiologists, Certified Anesthesia Assistants, and CRNAs. <u>Evaluating Compliance:</u> Review policies for definition of which staff roles require each level of certification Review personnel files for evidence of current certification Review random samples of clinical records (or cases from the operative log) and cross-check with personnel files to confirm a staff with current ACLS certification is present in the OR during every procedure.
11-I-8		B	C-M	C	Anesthesia professionals, both directly employed and contract anesthesia professionals, must be trained and knowledgeable with the facility's emergency protocol for		Verify all anesthesia personnel receive comprehensive emergency training to enable swift, coordinated responses to crises such as medical emergencies or disasters. The facility must provide training

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					cardio-pulmonary emergencies, safe and timely transfer of a patient to an alternative care facility when extended emergency care is needed, and other internal and external disasters.		upon hire (or when contracted staff begins working in the facility), annually, and when updates to emergency response protocols are updated. <u>Evaluating Compliance:</u> Review training materials for comprehensive content (e.g., medical emergencies, active threats) Interview anesthesia staff regarding emergency responses (e.g., location of emergency equipment, initiating patient transfer, evacuating an anesthetized patient during fire in the facility) Review personnel files for evidence of training (initial, annual, updates).
11-I-10	A	B	C-M	C	The operating room personnel are familiar with the equipment and procedures utilized in treating emergencies, as discussed in standards section 5-C: Emergency Protocols.		Verify all operating room staff receive comprehensive emergency training, including the location and use of emergency equipment, to enable swift, coordinated responses to crises such as medical emergencies or disasters. The facility must provide training upon hire (or when contracted staff begins working in the facility), annually, and when updates to emergency response protocols are updated. <u>Evaluating Compliance:</u> Review training materials for comprehensive content (e.g., use of emergency equipment, responses to active threats) Interview staff regarding emergency responses (e.g., location of emergency equipment, initiating patient transfer, evacuating an anesthetized patient during fire in the facility) Review personnel files for evidence of training (initial, annual, updates).
11-I-13	A	B	C-M	C	Where staff cannot demonstrate competency, training, or experience in the safe operation of equipment, the facility provides and documents training or arranges training through an external provider.		Verify staff receive thorough instruction on the effective use of facility equipment that is specific to their position. This allows staff to correctly operate complex medical devices, preventing misuse, malfunction, or harm to patients or themselves. Whether provided by the facility or an external representative, training content must align with the equipment's instructions for use. Competency should be accessed initially and periodically. <u>Evaluating Compliance:</u> Interview staff regarding: How the facility assesses competency to run specialized equipment (e.g., self-assessment, qualified peer observation) What equipment requires training by an external expert (e.g., robotic equipment, lasers)

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							Review personnel files for evidence of competency for job-specific equipment (initial, per policy).
11-I-15	A	B	C-M	C	Operating room personnel have adequate knowledge to treat malignant hyperthermia, cardiopulmonary resuscitation, and anaphylactic emergencies.		Verify all operating room personnel receive emergency training to enable swift, coordinated responses to medical emergencies, including Malignant Hyperthermia, Cardiopulmonary Resuscitation, and Anaphylaxis. The facility must provide training upon hire (or when contracted staff begins working in the facility), annually, and when updates to emergency response protocols are updated. Evaluating Compliance: Review training materials for required content Interview OR staff regarding: Emergency responses (activating a code, when to contact EMS, use of resuscitation forms) Location of emergency items (e.g., crash cart with ACLS drugs, MH drugs, succinylcholine) Process for patient transfer to the hospital Review personnel files for evidence of training (initial, annual, updates).
11-I-16	A	B	C-M	C	Health care professionals providing dental, surgical, and anesthesia services are prepared to respond to medical emergencies that may occur in conjunction with the services provided.		Verify all healthcare professionals providing dental, surgical, and anesthesia services receive emergency training to enable swift, coordinated responses to medical emergencies common to the services provided. The facility must provide training upon hire (or when contracted staff begins working in the facility), annually, and when updates to emergency response protocols are updated. Evaluating Compliance: Review training materials to confirm content aligns with risks from facility services Interview OR staff regarding: Emergency responses (activating a code, when to contact EMS, use of resuscitation forms) Location of emergency items (e.g., crash cart with ACLS drugs, MH drugs, succinylcholine) Process for patient transfer to the hospital Review personnel files for evidence of training (initial, annual, updates).

Section 16: Dubai Health Authority (DHA) DSC Supplemental

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
Sub-Section A : Personnel Qualifications							
16-A-1	A	B	C-M	C	All health facilities providing Day Surgical Services (DSS) shall adhere to Federal and Local Laws and Regulations.	DHA 5.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-2	A	B	C-M	C	Health facilities aiming to provide DSS shall comply with the DHA licensure and administrative procedures available on the DHA website https://www.dha.gov.ae	DHA 5.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-3	A	B	C-M	C	Licensed health facilities opting to add DSS shall inform Health Regulation Sector (HRS) and submit an application to HRS to obtain permission to provide the required service	DHA 5.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-4	A	B	C-M	C	Summary of Day Surgical Center (DSC) classification and minimum requirements are found in DHA appendix 1.	DHA 5.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 , https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-5	A	B	C-M	C	Day Surgical Centers shall be granted a license based on the Health Facility Classification and their permitted levels (DHA Appendix 2-4)	DHA 5.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf Appendix 2-4, Page 56/80
16-A-6	A	B	C-M	C	All Day Surgical Centers (DSC) are mandated to be accredited within two (2) years of licensure and to upload their accreditation certificate to the facility's Sheryan account.	DHA 5.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-7	A	B	C-M	C	The DSC shall adhere to the DHA Sentinel Events Notification and Management Policy.	DHA 5.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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							%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-8	A	B	C-M	C	DSC do not require to have a mortuary in-house, but will require to have a policy for mortuary management.	DHA 5.8	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-9	A	B	C-M	C	The DSC shall maintain a policy and procedures on medication management, medication storage and monitoring of medication inventory and expiration dates consistent with applicable federal and local legislation and regulations.	DHA 5.9	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-10	A	B	C-M	C	Adhere to the requirements in the DHA Policy for Emergency Medication as well as the DHA Guidelines for Pharmacy.	DHA 5.9.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-11	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Patient acceptance/referral criteria.	DHA 5.10 DHA 5.10.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-12	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Lab and diagnostic services and turn-around timeframes for reporting non-critical and critical results.	DHA 5.10 DHA 5.10.	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-13	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Patient assessment and admission criteria DHA 5.10.4	5.10 5.10.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-14	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Patient education, communication and informed consent.	DHA 5.10 DHA 5.10.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-A-15	A	B	C-M	C	Consent should include the need for higher sedation within the same facility or following transfer to a higher-level facility.	DHA 5.10.5a	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-16	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Staffing plan, staff management and clinical and privileging.	DHA 5.10 DHA 5.10.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-17	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Patient health record, confidentiality and privacy as per DHA policy for Health Information Assets Management.	DHA 5.10 DHA 5.10.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-18	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Patient health record, confidentiality and privacy as per DHA policy for Health Information Assets Management.	DHA 5.10 DHA 5.10.8	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-19	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Medication management and pharmacy services as per DHA Guidelines for Pharmacy.	DHA 5.10 DHA 5.10.11	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-20	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Medical and hazardous waste management as per the Dubai Municipality (DM) requirements.	DHA 5.10 DHA 5.10.13	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-21	A	B	C-M	C	There should be an allocated medical waste storage and collection area that is well ventilated and secured from public and patient access.	DHA 5.10.13a	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-22	A	B	C-M	C	The medical waste storage and collection area shall be adequately labelled with a hazard sign to prevent unexpected entry from patients or the public.	DHA 5.10.13b	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-A-23	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Laundry and housekeeping services	DHA 5.10 DHA 5.10.15	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-24	A	B	C-M	C	The DSC shall have in place internal policies and procedures including but not limited to: Violence against Staff/Zero Tolerance.	DHA 5.10 DHA 5.10.18	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-25	A	B	C-M	C	The health facility should ensure it has in place adequate lighting and utilities, including temperature controls, water taps, medical gases, sinks and drains, lighting, electrical outlets and communications.	DHA 5.11	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-26	A	B	C-M	C	The health facility shall maintain documented evidence of treatment protocols and care pathway for surgical procedures to include, but not be limited to the following: Referral criteria.	DHA 5.12 DHA 5.12.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-27	A	B	C-M	C	The health facility shall maintain documented evidence of treatment protocols and care pathway for surgical procedures to include, but not be limited to the following: Pre-op assessment and patient acuity classification.	DHA 5.12 DHA 5.12.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-28	A	B	C-M	C	The health facility shall maintain documented evidence of treatment protocols and care pathway for surgical procedures to include, but not be limited to the following: Surgical Safety Checklist for Surgical Procedures.	DHA 5.12 DHA 5.12.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-29	A	B	C-M	C	All DSC must have a written agreement for patient referral and emergency transfer to a nearby hospital setting. The transfer agreement shall detail the transfer plan/protocol of patients and meet Dubai transfer timeframes for emergency patients as per DHA Policy for Patient Referral and Inter-facility Transfer.	DHA 5.13	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-A-30	A	B	C-M	C	The DSC may provide necessary allied health services to meet patient needs and based on the facility's type of services.	DHA 5.14	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-A-31	A	B	C-M	C	Such services may be available on the premises or through a written agreement with an external provider.	DHA 5.14.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
Sub-section B: Health Facility Requirements							
16-B-1	A	B	C-M	C	Summary of Day Surgical Center (DSC) classification and minimum requirements are found in appendix 1.	DHA 6.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-2	A	B	C-M	C	DSC operational requirements include the following: Day surgical centers shall not operate or open between 12:00am and 6:00am.	DHA 6.2 DHA 6.2.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-3	A	B	C-M	C	DSC operational requirements include the following: Surgeries in DSC Class CM and Class C, requiring general anesthesia shall not start after 5:00pm.	DHA 6.2 DHA 6.2.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-4	A	B	C-M	C	DSC operational requirements include the following: Surgeries in DSC CM under deep sedation shall not exceed two (2) hours.	DHA 6.2 DHA 6.2.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-5	A	B	C-M	C	DSC operational requirements include the following: Surgeries in DSC C under deep sedation and or general anesthesia shall not exceed three (3) hours.	DHA 6.2 DHA 6.2.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-6	A	B	C-M	C	DSC operational requirements include the following: Multiple surgeries in different sites that exceed three (3) hours are not permitted.	DHA 6.2 DHA 6.2.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-7	A	B	C-M	C	Day Surgical Services shall be Consultant or Specialist Led services with a minimum of ten (10) years' experience in one of the main surgical specialties within the scope of the DSC.	DHA 6.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-B-8	A	B	C-M	C	The DSC can be specialized in one or more surgical specialty such as but not limited to the following: General Surgery (pediatric and/or adult)	DHA 6.4 DHA 6.4.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-9	A	B	C-M	C	The DSC can be specialized in one or more surgical specialty such as but not limited to the following: Dentistry	DHA 6.4 DHA 6.4.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-10	A	B	C-M	C	The DSC can be specialized in one or more surgical specialty such as but not limited to the following: Ophthalmology	DHA 6.4 DHA 6.4.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-11	A	B	C-M	C	The DSC can be specialized in one or more surgical specialty such as but not limited to the following: Vascular	DHA 6.4 DHA 6.4.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-12	A	B	C-M	C	The DSC can be specialized in one or more surgical specialty such as but not limited to the following: Orthopedic	DHA 6.4 DHA 6.4.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-13	A	B	C-M	C	The DSC can be specialized in one or more surgical specialty such as but not limited to the following: Obstetrics and Gynecology	DHA 6.4 DHA 6.4.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-14	A	B	C-M	C	The DSC can be specialized in one or more surgical specialty such as but not limited to the following: Gastroenterology	DHA 6.4 DHA 6.4.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-15	A	B	C-M	C	The DSC can be specialized in one or more surgical specialty such as but not limited to the following: Plastic Surgery	DHA 6.4 DHA 6.4.8	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-16	A	B	C-M	C	The health facility should meet the health facility requirement as per the DHA Health Facility Guidelines (HFG).	DHA 6.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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16-B-17	A	B	C-M	C	HRS must be informed and approve changes to existing or new services or staffing levels.	DHA 6.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-18	A	B	C-M	C	DSC should have a contract with the following types of healthcare facilities: A nearby hospital for: referral of urgent and emergency cases, ward and ICU Admissions (if required), Assessment and follow up with professionals, specialties and services not available or not within the scope of the DSC.	DHA 6.8 DHA 6.8.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-19	A	B	C-M	C	DSC should have a contract with the following types of healthcare facilities: External Laboratory service (Applicable to DSC class A, B and any DSC that provides solely vascular or ophthalmology services only).	DHA 6.8 DHA 6.8.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-20	A	B	C-M	C	DSC should have a contract with the following types of healthcare facilities: External Diagnostic imaging services (Applicable to DSC class A, B and any DSC that provides solely vascular or ophthalmology services only).	DHA 6.8 DHA 6.8.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-21	A	B	C-M	C	DSC should have a contract with the following types of healthcare facilities: Pharmacy service (if required).	DHA 6.8 DHA 6.8.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-22	A	B	C-M	C	DSC should have a contract with the following types of healthcare facilities: Rehabilitation service (if required).	DHA 6.8 DHA 6.8.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-23	A	B	C-M	C	DSC should have a contract with the following types of healthcare facilities: Home healthcare services (if required).	DHA 6.8 DHA 6.8.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-B-24	A	B	C-M	C	DSC should have a contract with the following types of healthcare facilities: Telehealth services (if required).	DHA 6.8 DHA 6.8.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-25	A	B	C-M	C	The surgical setup shall be capable of providing the required level of sedation/anesthesia and emergency response.	DHA 6.11	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-26	A	B	C-M	C	The Health Facility shall put in place annual simulation scenarios with all surgical teams to manage patient recovery and transfer.	DHA 6.12	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-27	A	B	C-M	C	Simulation outcome and improvement plans shall be documented.	DHA 6.12.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-28		B	C-M		Class B Day Surgical Centers will have sufficient medical equipment to manage permitted endoscopic procedures: Procedural sedation shall be performed in designated areas where the patient can be resuscitated if sedation is deeper than intended.	DHA 6.14 DHA 6.14.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-29		B	C-M		Class B Day Surgical Centers will have sufficient medical equipment to manage permitted endoscopic procedures: Practitioners should be ACLS certified and possess the skills necessary to resuscitate or rescue a patient whose level of sedation is deeper than initially intended.	DHA 6.14 DHA 6.14.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-30	A	B	C-M		Class A and B (without endoscopy) do not require a ventilator and will have the required medical equipment to manage permitted surgeries: Emergency Medical Service (EMS) call system;	DHA 6.15 DHA 6.15.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-31	A	B	C-M		Class A and B (without endoscopy) do not require a ventilator and will have the required medical equipment to manage permitted surgeries: Pulse oximeter	DHA 6.15 DHA 6.15.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-B-32		B	C-M	C	Class B (with endoscopy) and C Day Surgical Centers will have the required medical equipment to manage permitted surgeries: Emergency Medical Service (EMS) call system;	DHA 6.16 DHA 6.16.1 DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-33		B	C-M	C	Class B (with endoscopy) and C Day Surgical Centers will have the required medical equipment to manage permitted surgeries: Pulse oximeter and hemodynamic monitoring equipment shall include but not be limited to the following: · Central venous pressure · ABG	DHA 6.16 DHA 6.16.2 DHA 6.16.2.d DHA 6.16.2.f DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-34		B	C-M	C	Class B (with endoscopy) and C Day Surgical Centers will have the required medical equipment to manage permitted surgeries: One (1) portable ventilator is required for one (1) to four (4) OTs (backup)	DHA 6.16 DHA 6.16.3 DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-35		B	C-M	C	Class B (with endoscopy) and C Day Surgical Centers will have the required medical equipment to manage permitted surgeries: One ventilator is required for two beds in the recovery bay.	DHA 6.16 DHA 6.16.4 DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-36	A	B	C-M		DSC Class A and B shall ensure that the full-time surgeon is responsible for managing medications and record keeping in the DSC (Appendix 4).	DHA 6.17 DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-37		B	C-M	C	DSC Class B (with endoscopy) and C shall ensure the anesthetist is responsible for managing anesthesia, narcotic and controlled medications, emergency medicine, any other medication and record-keeping in the DSC (Appendix 4).	DHA 6.18 DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-38	A	B	C-M	C	DSC with pharmacy services, shall ensure the pharmacist is responsible for managing anesthesia, narcotic and controlled medications, emergency medicine, any other medication and record-keeping in the DSC (Appendix 4).	DHA 6.19 DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-39	A	B	C-M	C	DSC that provide ambulatory care pharmacy services must employ a full time pharmacist.	DHA 6.20 DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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							https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-40	A	B	C-M	C	The pharmacy service should include storage of medication, medication preparation, dispensing and safe disposal. Refer to DHA Guidelines for Pharmacy	DHA 6.20.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-41	A	B	C-M	C	In the absence of a pharmacist (sick leave, emergency leave or annual leave), the anesthetists shall be responsible for managing anesthesia, narcotic and controlled medications, emergency medicine, any other medication and record-keeping. Refer to DHA Guidelines for Pharmacy	DHA 6.20.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-42	A	B	C-M	C	All DSC shall have access to laboratory and diagnostic services as per patient needs determined by the services provided and the medical team.	DHA 6.21	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-43	A	B	C-M	C	Refer to DHA Standards for Clinical Laboratory Services and DHA Standards for Diagnostic Services.	DHA 6.21.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-44	A		C-M		Class A DSC categories must provide: · Point of Care Testing for glucose, dipstick urinalysis and pregnancy test. · Radiology services as per patient need may be contracted with an external radiology provider.	DHA 6.23.1.a DHA 6.23.1.c	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-45		B	C-M		Class B DSC categories must provide: · Point of Care Testing for glucose, prothrombin time/international normalized ratio (PT/INR), dipstick urinalysis, and pregnancy test. · Radiology services as per patient need may be contracted with an external radiology provider.	DHA 6.23.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-46			C-M	C	Class C DSC categories must provide: · Point of Care Testing for glucose, prothrombin time/international normalized ratio (PT/INR), dipstick urinalysis, and pregnancy test. · Arterial Blood Gas (ABG)	DHA 6.23.3 DHA 6.23.3.a DHA 6.23.3.b	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-B-47			C-M	C	Class C DSC categories must provide essential onsite radiology services. · Radiology (or mobile x-ray) should include plain x-rays and chest x-rays. · The remaining radiology services as per patient need may be contracted with an external radiology provider.	DHA 6.23.4 DHA 6.23.4.a DHA 6.23.4.b	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-48			C-M	C	DSC class C providing solely Ophthalmology services shall have a Point of Care Testing (POCT) for glucose, dipstick urinalysis and pregnancy test. Any lab or radiology services may be contracted with an external provider.	DHA 6.24	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-49			C-M	C	Inhouse radiology services is optional for DSC class C providing solely Vascular services.	DHA 6.25	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-50	A	B	C-M	C	The DSC shall maintain a copy of operator and safety manuals of all medical equipment and inventory list with equipment location. All Medical Equipment should be registered and documented properly in the inventory which will be updated every time a new equipment arrives prior to use.	DHA 6.28	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-51	A	B	C-M	C	The inventory includes all in-use medical equipment only. No medical equipment that is not in use or not maintained should be stored in the facility.	DHA 6.29	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-52	A	B	C-M	C	The medical equipment Inventory include the following: a. Device name b. Description of the device c. The name of the factory d. The supplying company (agent) e. Year of purchase f. Section (location) g. Serial number h. Duration of preventive maintenance work (PM) i. Last day of maintenance & the next one due j. Periodic maintenance reports (qualitative and quantitative tests)	DHA 6.29.1.a - j	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-53	A	B	C-M	C	Many healthcare facilities use external contractor and/or services to provide specific services essential to the	DHA 6.30	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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					ongoing operation of the DSC, e.g. nutrition, laundry, cleaning, maintenance, transport, and security.		https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-54	A	B	C-M	C	Some clinical services may be provided by an external contractor such as radiology, lab and pathology and allied health.	DHA 6.31	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-55	A	B	C-M	C	External service providers shall be managed effectively to provide safe, high-quality care and services.	DHA 6.32	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-56	A	B	C-M	C	All DSC shall have a Business Continuity Plan to ensure the core functions of the center are met.	DHA 6.33	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-57	A	B	C-M	C	DSC must put in place a written policy that adheres to DHA requirements for patient rights and responsibilities as per the Ministerial Decision No. (14) of 2021 concerning the Patient Rights and Duties Charter	DHA 6.34	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-58	A	B	C-M	C	Information on patients' rights and responsibilities shall be communicated and displayed in at least two languages (Arabic and English) at the entrance, reception, and waiting for the area(s) of the premises and website.	DHA 6.34.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-59	A	B	C-M	C	Key Performance Indicators (KPIs) shall be captured by DSC management by the 2nd week of each quarter and reported to HRS as per the DHA Guidelines for Reporting Standalone Day Surgery Center Key Performance Indicators.	DHA 6.35	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-B-60	A	B	C-M	C	Submission reflects the outcomes achieved in the previous quarter. Data submission includes but is not limited to the following: a. Access b. Quality	DHA 6.35.1 DHA 6.35.1.a DHA 6.35.1.b	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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Sub-section C: Healthcare Professionals Requirements							
16-C-1	A	B	C-M	C	All healthcare professionals in the health facility shall hold an active DHA professional license and work within their scope of practice and granted privileges.	DHA 7.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-2	A	B	C-M	C	The privileging committee and/or medical director of the health facility shall privilege the physician aligned with his/her education, training, experience and competencies. The privilege shall be reviewed and revised on regular intervals as per the DHA Policy for Clinical Privileging.	DHA 7.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-3	A	B	C-M	C	Additional multidisciplinary staff must be in place as per specialization, continuity of care, service descriptions, scope and patient volume.	DHA 7.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-4	A	B	C-M	C	The standalone DSC shall comply with the minimum requirements: There must be one full time licensed physician with the role of Medical Director.	DHA 7.3.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-5	A	B	C-M	C	The standalone DSC shall comply with the minimum requirements: At least one full time licensed specialist or consultant surgeon present in the DSC.	DHA 7.3.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-6	A	B	C-M	C	The standalone DSC shall comply with the minimum requirements: The specialist or consultant surgeon and anesthesiologist must always be present until the patient is discharged or transferred to a higher level healthcare setting.	DHA 7.3.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-7		B			The standalone DSC shall comply with the minimum requirements: At least one part time anesthetist is required in Class B (with endoscopy) where permitted narcotics, and dissociative anesthetics are being administered for endoscopic procedures (Appendix 4).	DHA 7.3.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-8				C	At least one full-time anesthetist must be present in DSC Class C.	DHA 7.3.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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							https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-9	A	B	C-M	C	For Endoscopic Standards, refer to the DHA Standards for Endoscopy Services	DHA 7.3.8	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-10	A	B	C-M	C	Pediatric cases should be managed and treated only by professionals within the pediatric specialty (e.g.: pediatric surgery) or by a health care professional who is privileged to conduct the procedure and must have evidence of training in managing pediatric cases and PALS certified.	DHA 7.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-11	A	B	C-M	C	The treating surgeon shall be available at the DSC facility until the patient is discharged safely.	DHA 7.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-12	A	B	C-M	C	Healthcare professionals engaged in surgery shall maintain up to date hands-on in: Advanced Cardiac Life Support (ACLS) applicable to all healthcare professionals working within the scope of medicine.	DHA 7.6 DHA 7.6.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-13	A	B	C-M	C	Healthcare professionals engaged in surgery shall maintain up to date pediatrics Advanced Life Support (PALS) applicable to all healthcare professionals working within the scope of pediatrics. Ands-on in:	DHA 7.6 DHA 7.6.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-14	A	B	C-M	C	Healthcare professionals engaged in surgery shall maintain up to date hands-on in: Advanced Trauma Life Support (ATLS) applicable to all healthcare professionals working within the scope of surgery.	DHA 7.6 DHA 7.6.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-15	A	B	C-M	C	If the DSC manages pediatric cases, DSC must ensure all professionals managing pediatric cases (e.g.: Pediatricians, anesthesiologists and nurses) are trained in managing pediatric cases and PALS certified.	DHA 7.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-16	A	B	C-M	C	Visiting surgeons shall be available twenty-four (24) hours after the procedure.	DHA 7.8	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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							https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-17	A	B	C-M	C	Visiting surgeons must always ensure their patients are handed over to a competent physician(s) to oversee patient follow up and patient care during their absence.	DHA 7.8.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-18	A	B	C-M	C	The handover process should include a signed document on the patient care plan.	DHA 7.8.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-19	A	B	C-M	C	For DSC that provide full radiology/diagnostic services, one full time consultant/specialist radiologist shall be available to supervise and manage radiology services in the DSC.	DHA 7.9	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-20	A	B	C-M	C	At least one radiography technician shall be available in each shift and shall only be responsible for essential radiography services.	DHA 7.9.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-21	A	B	C-M	C	For DSC that provide full laboratory services, one full time DHA licensed pathologist shall be available to supervise and manage the clinical laboratory services in the DSC.	DHA 7.10	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-C-22	A	B	C-M	C	At least one laboratory technician shall be available in each shift and shall only be responsible for essential laboratory services.	DHA 7.10.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
Sub-section D: Pre-Operative Evaluation and Informed Consent							
16-D-1	A	B	C-M	C	All Day Surgical Centers must have in place a written Surgical Care Pathway (Appendix 5).	DHA 8.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-2	A	B	C-M	C	Day Surgical Center shall only provide surgical and diagnostic procedures for ASA-PS Classification I, II and III patients in both adults and pediatrics (appendix 3-4).	DHA 8.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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							https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-3	A	B	C-M	C	ASA-PS classification III patients must have a medical consultation, assessment and clearance as per their medical morbidities prior to any day surgical procedures under deep sedation and/or general anesthesia.	DHA 8.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-4	A	B	C-M	C	For patient selection criteria in dentistry under general anesthesia refer to Appendix 12.	DHA 8.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-5	A	B	C-M	C	Only permitted procedures are performed in the Day Surgical Center. For a list of permitted procedures by DSC Classification, refer to the following link: https://www.dha.gov.ae/uploads/092023/List%20of%20Permitted%20Procedures%20by%20Day%20Surgical%20Center%20Classification2023951570.pdf	DHA 8.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-6	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Emergency/unprepared patients.	DHA 8.6 DHA 8.6.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-7	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Inpatients.	DHA 8.6 DHA 8.6.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-8	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Uncooperative patients.	DHA 8.6 DHA 8.6.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-9	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Patients with a history of sleep apnea.	DHA 8.6 DHA 8.6.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-10	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Patients with a history of drug or alcohol abuse.	DHA 8.6 DHA 8.6.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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							https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-11	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Patients with airway difficulties.	DHA 8.6 DHA 8.6.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-12	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Patients with severe allergies.	DHA 8.6 DHA 8.6.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-13	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Patients with at risk of blood loss, excessive bleeding and may require a blood transfusion.	DHA 8.6 DHA 8.6.8	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-14	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Patients that require cardiac catheterization or Interventional Cardiology	DHA 8.6 DHA 8.6.9	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-15	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Patients with metabolic disorders (ASA IV and above).	DHA 8.6 DHA 8.6.10	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-16	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: High-risk patients (ASA IV-VI) in accordance with the American Society of Anesthesiologists (ASA) Classifications.	DHA 8.6 DHA 8.6.11	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-17	A	B	C-M	C	The following exclusions must be considered during patient consultations and pre-op assessments: Patients who require surgical procedure, intra or immediate post-operative care from a specialized healthcare professional or a specific service not within the scope and available services and professionals of the DSC.	DHA 8.6 DHA 8.6.12	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-18	A	B	C-M	C	Prior to patient referral for surgery, patients with ASA Classification III should:	DHA 8.7 DHA 8.7.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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					Have a thorough consultation with appropriate laboratory tests with the treating physician within the DSC or other healthcare facility, prior to the surgery.		https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-19	A	B	C-M	C	Prior to patient referral for surgery, patients with ASA Classification III should: Have evidence of the assessment and feedback e.g.: referral letter, medical report or other communication evidence between the healthcare team and a follow-up appointment with the physician to discuss surgical and non-surgical options.	DHA 8.7 DHA 8.7.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-20	A	B	C-M	C	If the surgical procedure requires higher-level sedation, which does not align with the existing day surgical category, then the provider is required to refer the patient to a higher facility category.	DHA 8.8	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-21	A	B	C-M	C	Surgical procedures are limited to those where there is only a small risk of surgical and anesthetic complications and hospitalization.	DHA 8.8.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-22	A	B	C-M	C	A comprehensive pre-op patient assessment process and testing shall be achieved with the support of a multi-disciplinary team (as applicable) and based on each patient's clinical and priority needs.	DHA 8.9	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-23	A	B			For DSC Class A and B: blood pressure, blood glucose, BMI and exclusions noted in Standard 2 should form part of the pre-op assessment.	DHA 8.9.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-24				C	For Class C: pre-op assessment should include but not limited to: · CBC · Blood glucose · Coagulation profile · BMI · And exclusions noted in Standard 3 (8.6 through 8.6.12)	DHA 8.9.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-25	A	B	C-M	C	Patients undergoing elective surgery shall provide their consent at pre-op assessment.	DHA 8.9.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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					a. The timeframe from pre-op assessment to surgery shall be conducted within 4-weeks. Patients exceeding the 4-week window should be re-assessed. b. Patients or their next of kin/legal guardian shall be given written information/instructions on the surgery and surgical preparation. c. Patients shall be given sufficient time to make an informed decision before surgery. d. The physician shall be available to answer any further questions in a non-technical way. e. Consent should be available in both English and Arabic languages. The minimum requirements for informed consent are set out in Appendix 6		https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-26	A	B	C-M	C	A Physician, Anesthetists (if applicable) and RN must document, complete and verify the Surgical Safety Checklist (Appendix 7).	DHA 8.10.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-27		B			All surgeries under Day Surgical Center category B must always be overseen by: a. A DHA licensed surgeon and nurse b. An anesthetist (part-time) must be present if narcotic drugs are being used for permitted endoscopic procedures (Appendix 4).	DHA 8.10.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-28				C	All surgeries under Day Surgical Center category C must always be overseen by a DHA licensed surgeon, anesthetist and nurse. The surgical team shall be competent to stabilize critically ill patients and transfer them to a higher level of care if the health facility cannot manage the patient onsite.	DHA 8.10.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-29	A	B	C-M	C	Minimally invasive procedures shall follow Procedural Sedation and Analgesia (PSA), as per the permitted levels of sedation per DSC facility type.	DHA 8.11	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-30	A	B	C-M	C	The DHA Licensed anesthetist shall hold valid certification in conscious sedation and be trained and competent in: Understanding the continuum of sedation and apply methods and levels of sedation, conscious sedation and	DHA 8.12 DHA 8.12.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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					associated risks of moderate/deeper sedation training and required competencies (Appendix 8-9).		
16-D-31	A	B	C-M	C	The DHA Licensed anesthetist shall hold valid certification in conscious sedation and be trained and competent in: Being able to conduct a physical assessment to assess the fitness and appropriateness of the patient for PSA.	DHA 8.12 DHA 8.12.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-32	A	B	C-M	C	The DHA Licensed anesthetist shall hold valid certification in conscious sedation and be trained and competent in: Discharging the patient, including but is not limited to the following checks: a. The patient returned to their baseline level of consciousness. b. Vital signs are stable and within acceptable limits c. Sufficient time has elapsed following administration of reversal agents (if applicable) to ensure that patient is not re-sedated. d. All recovery assessments, discharge and home release, have been met and completed (Appendix 10-11).	DHA 8.12 DHA 8.12.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-D-33	A	B	C-M	C	The DHA Licensed anesthetist shall hold valid certification in conscious sedation and be trained and competent in: Being able to discuss where and when deeper levels of sedation or anesthesia may be indicated.	DHA 8.12 DHA 8.12.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
Sub-section E: Patient Safety, Monitoring and Discharge							
16-E-1	A	B	C-M	C	The following should be considered and documented in the patient record: Patient identity (including history and family history).	DHA 9.1 DHA 9.1.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-2	A	B	C-M	C	The following should be considered and documented in the patient record: Evidence of consultation, physical examinations and confirmatory lab or diagnostics (patient selection).	DHA 9.1 DHA 9.1.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-3	A	B	C-M	C	The following should be considered and documented in the patient record:	DHA 9.1 DHA 9.1.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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					Procedure to be undertaken and location with clear markings.		https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-4	A	B	C-M	C	The following should be considered and documented in the patient record: No emerging issues since the last pre-op assessment.	DHA 9.1 DHA 9.1.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-5	A	B	C-M	C	The following should be considered and documented in the patient record: Verification of Nothing by Mouth Status.	DHA 9.1 DHA 9.1.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-6	A	B	C-M	C	The following should be considered and documented in the patient record: Mitigating circumstances/exclusions not to perform the surgery (6.2.3. and Appendix 3).	DHA 9.1 DHA 9.1.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-7	A	B	C-M	C	The following should be considered and documented in the patient record: Adequate staff levels for the procedure.	DHA 9.1 DHA 9.1.8	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-8	A	B	C-M	C	The following should be considered and documented in the patient record: Sedation/anesthesia and recovery plan.	DHA 9.1 DHA 9.1.10	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-9	A	B	C-M	C	The following should be considered and documented in the patient record: Document adherence to the Surgical Safety Checklist (Appendix 7) for all surgeries.	DHA 9.1 DHA 9.1.11	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf Appendix 7 - page 66/80
16-E-10	A	B	C-M	C	The following should be considered and documented in the patient record: Control of concentrated electrolyte solutions.	DHA 9.1 DHA 9.1.12	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-11	A	B	C-M	C	The following should be considered and documented in the patient record: Assuring medication accuracy and safe dosing.	DHA 9.1 DHA 9.1.13	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-E-12	A	B	C-M	C	The following should be considered and documented in the patient record: Avoiding catheter and tubing misconnections.	DHA 9.1 DHA 9.1.14	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-13	A	B	C-M	C	The following should be considered and documented in the patient record: Single-use of injection devices and insert of the IV line.	DHA 9.1 DHA 9.1.17	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-14	A	B	C-M	C	There are several patient safety measures that should be considered and documented in facility logbook such as and not limited to: Confirmation of functioning equipment and a back-up plan.	DHA 9.2 DHA 9.2.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-15	A	B	C-M	C	There are several patient safety measures that should be considered and documented in facility logbook such as and not limited to: A list of look-alike, sound-alike medication.	DHA9.2 DHA 9.2.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-16	A	B	C-M	C	All patient diagnostic or surgical procedures shall be continuously monitored in accordance with the surgical procedure, patient safety and risk factors.	DHA 9.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-17	A	B	C-M	C	Minor procedures performed under topical or local anesthesia, not involving drug-induced alteration of consciousness other than minimal preoperative anti-anxiety medications (e.g. mole removals or incision and drainage of superficial abscesses) maybe performed by a DHA licensed physician or dentist within their scope of practice and privileges.	DHA 9.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-18	A	B	C-M	C	When moderate sedation is targeted, the healthcare professional is assigned responsibility for patient monitoring and may perform brief interruptible tasks.	DHA 9.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-19	A	B	C-M	C	Monitoring includes an electronic assessment of blood pressure, respiratory rate, heart rate and pulse oximetry combined with visual monitoring of the patient's level of consciousness and discomfort.	DHA 9.5.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-E-20	A	B	C-M	C	Procedures that require the use of deep sedation/analgesia, general anesthesia, or major conduction blockade (e.g. liposuction) may be serious or life-threatening (Appendix 3-4).	DHA 9.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-21	A	B	C-M	C	Major regional blocks include but are not limited to the spinal, epidural or caudal injection of any drug, which has analgesic, anesthetic or sedative effects.	DHA 9.6.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-22	A	B	C-M	C	When deep sedation or general anesthesia is targeted, the anesthetist is responsible for patient monitoring must be dedicated solely to that task and be readily available to take the necessary action to ensure patient safety during the procedure.	DHA 9.6.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-23	A	B	C-M	C	The DSC shall put in place procedures to rescue patients who are sedated deeper than intended.	DHA 9.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-24	A	B	C-M	C	Documentation of the clinical assessments and monitoring data during sedation and recovery and discharge is required to include: Food consumption appropriate for the patient and consistent with the patient's condition, and clinical care shall be provided.	DHA 9.8 DHA9.8.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-25	A	B	C-M	C	Documentation of the clinical assessments and monitoring data during sedation and recovery and discharge is required to include: Ability to pass urine following surgery.	DHA 9.8 DHA 9.8.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-26	A	B	C-M	C	Documentation of the clinical assessments and monitoring data during sedation and recovery and discharge is required to include: Patient-level of consciousness and ability to put on clothing without assistance.	DHA 9.8 DHA 9.8.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-27	A	B	C-M	C	A discharge plan shall start from patient admission and include various personnel, information and resources.	DHA 9.9	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-E-28	A	B	C-M	C	Considerations for discharge preparation shall include but not be limited to: Medication needed from the pharmacy.	DHA 9.10.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-29	A	B	C-M	C	Considerations for discharge preparation shall include but not be limited to: Physician written authorization for discharge.	DHA 9.10.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-30	A	B	C-M	C	Considerations for discharge preparation shall include but not be limited to: Documentation of the procedure for the patient and treating physician.	DHA 9.10.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-31	A	B	C-M	C	Considerations for discharge preparation shall include but not be limited to: No driving policy and travel distance to home.	DHA 9.10.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-32	A	B	C-M	C	Considerations for discharge preparation shall include but not be limited to: Environmental conditions, such as stairs, access to toilet or bedroom.	DHA 9.10.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-33	A	B	C-M	C	The carer's/authorized persons contact details and their awareness of possible issues and requirements following discharge.	DHA 9.11	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-34	A	B	C-M	C	Contact numbers after discharge, such as the doctor or emergency contact. a. Follow up phone call and follow up appointments	DHA 9.11.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-35	A	B	C-M	C	The treating physician shall respect patients' choices if they decide to Discharge Against Medical Advice (AMA).	DHA 9.11.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-E-36	A	B	C-M	C	AMA patients must sign a form before leaving the facility and be witnessed by the treating physician and a nurse.	DHA 9.11.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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							https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
Sub-section F: Critical Care and Emergency Management							
16-F-1	A	B	C-M	C	DSC shall have written policies and procedures must be established and implemented. They should define and describe the scope of critical care services that ensure safe and competent delivery of the patients' services.	DHA 10.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-2	A	B	C-M	C	The DSC shall ensure there is one competent Registered Nurse (RN) during surgery with suitable training and experience in critical care on duty to provide the critical care services if required.	DHA 10.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-3	A	B	C-M	C	Evidence of the competency and training shall include the following: • Recognizing arrhythmias. • Assisting the physician in placing central lines or arterial lines. • Obtaining blood gases ABG's. • Central Venous Pressure (CVP). • Glasgow Coma Scale (GSC) • Point of Care Testing • Training in using defibrillator and care of patients on ventilators.	DHA 10.2.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-4	A	B	C-M	C	The DSC shall ensure periodic training and education for staff in the use of equipment for emergency management.	DHA 10.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-5	A	B	C-M	C	Training and assessment of competency shall be documented as per the requirements of the training provider.	DHA 10.3.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-6	A	B	C-M	C	The ratio of recovery rooms should consider the number of surgical theatres, hours of operation, procedures being performed and patient scheduling.	DHA 10.5.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
16-F-7	A	B	C-M	C	Critical care services equipment and supplies must be immediately available in the DSC for the immediate and safe provision of care and treatment required.	DHA 10.5.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-8	A	B	C-M	C	At a minimum, DSC shall have a clear protocol and provision for essential emergency management for illness and/or injection injuries that occurred for the patient, healthcare professionals, employees or visitors, which needs immediate emergency care and assistance before transport to another health facility.	DHA 10.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-9	A	B	C-M	C	Emergency services must be provided by qualified and licensed physician(s) who are authorized by their scope of practice to provide emergency services and received privileges from the facility to perform specific emergency procedures.	DHA 10.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-10	A	B	C-M	C	RN providing emergency services in the DSC shall be trained and competent to provide the emergency care, as needed: Patient Triage.	DHA 10.8 DHA 10.8.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-11	A	B	C-M	C	RN providing emergency services in the DSC shall be trained and competent to provide the emergency care, as needed: Operating a Cardiac Monitor.	DHA 10.8 DHA 10.8.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-12	A	B	C-M	C	RN providing emergency services in the DSC shall be trained and competent to provide the emergency care, as needed: ECG Recording and Interpretation.	DHA 10.8 DHA 10.8.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-13	A	B	C-M	C	RN providing emergency services in the DSC shall be trained and competent to provide the emergency care, as needed: Pulse Oximetry.	DHA 10.8 DHA 10.8.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-14	A	B	C-M	C	RN providing emergency services in the DSC shall be trained and competent to provide the emergency care, as needed: Oxygen Administration.	DHA 10.8 DHA 10.8.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

Standard ID	Class				Standard Language	Regulation	Interpretive Guidance
16-F-15	A	B	C-M	C	RN providing emergency services in the DSC shall be trained and competent to provide the emergency care, as needed: Suctioning.	DHA 10.8 DHA 10.8.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-16	A	B	C-M	C	RN providing emergency services in the DSC shall be trained and competent to provide the emergency care, as needed: Intravenous cannulation.	DHA 10.8 DHA 10.8.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-17	A	B	C-M	C	RN providing emergency services in the DSC shall be trained and competent to provide the emergency care, as needed: Emergency services will be available during the operational hours of the DSC.	DHA 10.8 DHA 10.8.9	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-18	A	B	C-M	C	Emergency Medications must be available in all DSCs as per DHA Emergency Medications Policy.	DHA 10.9	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-19	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Resuscitation kit, cardiac board and oral airways.	DHA 10.10 DHA 10.10.3	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-20	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Laryngoscope with blades.	DHA 10.10 DHA 10.10.4	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-21	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Diagnostic set.	DHA 10.10 DHA 10.10.5	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-22	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Patient trolley with an IV stand.	DHA 10.10 DHA 10.10.6	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-23	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening	DHA 10.10 DHA 10.10.7	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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					conditions shall include but not limited to the following: Nebulizer		https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-24	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Refrigerator for medication.	DHA 10.10 DHA 10.10.8	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-25	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Floor Lamp (Operating light mobile).	DHA 10.10 DHA 10.10.9	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-26	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Sets of instruments shall include suturing set, dressing set, foreign body removal set or minor set and cut down set.	DHA 10.10 DHA 10.10.10	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-27	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Disposable supplies shall include the following: · Suction tubes (all sizes) · Tracheostomy tube (all sizes) · Intravenous cannula (different sizes) · Syringes (various sizes) · Dressings (gauze, sofra-tulle) · Crepe bandages (sizes) · Splints (Thomas splints, cervical collars, finger splints).	DHA 10.10 DHA 10.10.11	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-28	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Glucometer	DHA 10.10 DHA 10.10.12	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-29	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Sufficient electrical outlets to satisfy monitoring equipment requirements, including clearly labelled outlets connected to an emergency power supply.	DHA 10.10 DHA 10.10.13	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

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16-F-30	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Portable vital signs monitor (ECG, Pulse-Oximetry, Temperature, NIBP, EtCO2).	DHA 10.10 DHA 10.10.15	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-31	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: One portable ventilator is required for (1) one to (4) four OTs (backup)Note: EtCo2, ventilators and defibrillator are not required in DSC level A and level B (without endoscopy).	DHA 10.10 DHA 10.10.17	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-32	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: Policy for maintaining personal items and food in the emergency area shall be established and maintained by the health facility.	DHA 10.10 DHA 10.10.19	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-33	A	B	C-M	C	Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following: A record must be kept for each patient receiving emergency services and integrated into the patient's health records. The record shall include patient name, date, time and method of arrival, physical findings, care, and treatment. Name of treating physician and discharging/transferring time.	DHA 10.10 DHA 10.10.20	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-34	A	B	C-M	C	Well-equipped ambulance services shall be ready and nearby with licensed, trained and qualified Emergency Medical Technicians (EMT) for patient transportation if required.	DHA 10.11	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-35	A	B	C-M	C	The service can be outsourced with a written contract with an emergency services provider licensed in Dubai.	DHA 10.11.1	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023 https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf
16-F-36	A	B	C-M	C	Ambulance services shall meet Dubai emergency transfer timeframes.	DHA 10.11.2; 10.11.2	DHA Standards for Standalone Day Surgery Centers, Version 4, Effective date 1/11/2023

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							https://www.dha.gov.ae/uploads/092023/Standards%20for%20Standalone%20Day%20Surgery%20Centres%20Final202397280.pdf

GENERAL GLOSSARY FOR ALL PROGRAMS

Adequate: Satisfactory or acceptable in quality or quantity, encompassing size, space, maintenance, cleanliness, freedom from clutter, lighting, equipment, and supplies, etc.; it is meant to satisfy a requirement.

Advanced Cardiac Life Support (ACLS): A course that trains and certifies participants in a set of clinical guidelines for the urgent and emergent treatment of life-threatening cardiovascular conditions in adults that will cause or have caused cardiac arrest using advanced medical procedures, medications, and techniques through didactic and hands-on skills return demonstration sessions. It builds on the foundation of lifesaving basic life support (BLS) skills. It reflects science and education from the *American Heart Association Guidelines Update for CPR and Emergency Cardiovascular Care (ECC)*. The course is approved by the American Heart Association (AHA) or an identical content course that conforms to the current AHA Guidelines.

***** Advanced practice registered nurses (APRNs):** Licensed registered nurses educated at a master's or doctoral level and in a specific role and patient population. APRNs are prepared with specialized education and certification to assess, diagnose, and manage medical issues. They can also order tests and prescribe medications. APRNs include:

- 1) Certified registered nurse anesthetist (CRNA).
- 2) Certified nurse practitioner (CNP).
- 3) Clinical nurse specialist (CNS).
- 4) Certified nurse midwife (CNM).

Adverse event: An incident in health care that causes unintended harm to patients or providers and is often preventable. Common adverse events include but are not limited to, medication errors, surgical mistakes, infections acquired in healthcare settings, falls, pressure ulcers, and communication failures. All adverse events that occur within 30 (thirty) days of the procedure must be reported to QUAD A contemporaneously when the facility learns of the event.

Air Exchanges Per Hour (ACH): The number of times that the total air volume in a room or space is completely removed and replaced in an hour.

***** Ambulatory surgical center (ASC):** Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC and must meet the conditions set forth in subparts B and C of 416.2. **[42 CFR 416.2]**

Ambulatory Services: for the period before January 1, 2008, facility services that are furnished in an ASC, and beginning January 1, 2008, means the combined facility services and covered ancillary services that are furnished in an ASC in connection with covered surgical procedures. **[42 CFR 416.2]**

Anesthesia professional: A physician anesthesiologist, Certified Registered Nurse anesthetist (CRNA), Certified Anesthesiologist Assistant (CAA), and an appropriately credentialed Oral and Maxillofacial Surgeon.

**** Antisepsis:** The application of an antimicrobial chemical to the skin or mucous membrane to reduce the microbial population.

**** Antiseptic:** An agent used for antisepsis (to kill microorganisms or substantially inhibit their growth).

**** Autoclave:** A common term applied to the performance of steam sterilization under pressure, where bacteria are killed (including spores).

***** Appropriate/appropriately** means especially suitable or compatible; or fitting.

Examples:

- Administrative and patient care areas must have lighting to see all tasks fully.
- Laryngoscopes are cleaned according to the manufacturer's recommendations, though sterilization is preferred.
- Oxygen delivery should be tailored to the appropriate delivery method based on patient need and type/location of the procedure.

Auxiliary Staff: Unlicensed staff who are not state-certified/licensed to independently evaluate patient physical status and cannot legally provide emergency duties beyond Basic Life Support for Healthcare Providers. Auxiliary staff includes dental assistants, registered/certified dental assistants, dental anesthesia/sedation assistants, medical assistants, surgical technicians, and other non-independently Licensed Providers.

Basic Life Support (BLS): A course that trains and certifies participants to promptly recognize several life-threatening emergencies, give high-quality chest compressions, deliver appropriate ventilations, and provide early use of an automatic external defibrillator (AED) through both didactic and hands-on skills return demonstration sessions. It reflects science and education from the *American Heart Association Guidelines Update for CPR and Emergency Cardiovascular Care (ECC)* and is approved by the American Heart Association (AHA) or an identical content course that conforms to the current AHA Guidelines.

**** Biological Indicator (BI):** A sterilization process monitoring device commercially prepared with a known population of highly resistant spores that tests the effectiveness of the sterilization method being used. The indicator is used to demonstrate that the conditions necessary to achieve sterilization were met during the sterilizer cycle being monitored.

Business Associate Agreement (BAA): A contract between the facility and an external business or individual that performs certain functions or activities on behalf of, or provides a service to, the facility when the function, activity, or service involves the creation, receipt, maintenance, or transmission of Protected Health Information (PHI) by the business or individual. The agreement establishes the permissible uses and disclosures of PHI by the business associate, how the business associate will support patients' Privacy Rule rights, and the responsibilities of both parties to maintain the privacy and security of PHI. The Health Insurance Portability and Accountability Act (HIPAA) Rules generally require that covered entities and

business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard protected health information.

***** Certified Anesthesiologist Assistant (CAA):** A master's degree level non-physician anesthesia care provider that:

- 1) Is certified by the National Commission for Certification of Anesthesiologist Assistants (NCAA) Note: not a CMS requirement
- 2) Works under the direction of an anesthesiologist.
- 3) Is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on nonphysician anesthetists; and
- 4) Is a graduate of a medical school-based anesthesiologist's assistant educational program that—
 - a) Is accredited by the Committee on Allied Health Education and Accreditation; and
 - b) Includes approximately two (2) years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

***** Certified Registered Nurse Anesthetist (CRNA):** An advanced practice registered nurse (APRN) who administers anesthesia and other medications. Physician Supervision (either the operating practitioner or of an anesthesiologist who is immediately available if needed) is required if required by state or federal law.

- 1) Is licensed as a registered professional nurse by the State in which the nurse practices.
- 2) Meets any licensure requirements the State imposes with respect to nonphysician anesthetists.
- 3) Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs, or such other accreditation organization as may be designated by the Secretary; and
- 4) Meets the following criteria:
 - (I) Has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary; or
 - (ii) Is a graduate of a program described in paragraph (3) of this definition and within 24 months after that graduation meets the requirements of paragraph (4)(I) of this definition.
- 5) For certified registered nurse anesthetist services, the certified registered nurse anesthetist may review and verify (sign and date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team, including, as applicable, notes documenting the certified registered nurse anesthetist's presence and participation in the service.

**** Chemical Indicator (CI):** A sterilization monitoring device used to monitor the attainment of one (1) or more critical parameters required for sterilization. A characteristic color or other visual change indicates a defined level of exposure based on the classification of the chemical indicator used.

*****Clinic:** A facility (Rural Health Clinic (RHC)) that is established primarily to furnish outpatient physician services and that meets the following tests of physician involvement:

- The medical services are furnished by a group of three or more physicians practicing medicine together.
- A physician is present during all hours of operation of the clinic to furnish medical services, as distinguished from purely administrative services. **[485.703 Condition]**

*****Clinic Administrator:** The individual responsible for the internal operation of the RHC in accordance with written policies. A qualified Clinic Administrator is designated by the facility's governing body. **[§485.705(c)(1) and §485.709(b)]**

***** Clinical Personnel:** The entire clinical team providing services in the facility, including, but not limited to, all physicians/surgeons/proceduralists, anesthesia providers, nurses, scrub techs, physician assistants, physical/occupational/speech therapists and assistants, social workers, clinical psychologists, marriage and family therapists, mental health counselors, medical assistants, etc. Employment status (owner, employee, contractor, contracted, indirect employee, prn staff, etc.) is not a factor in defining who is included as Clinical Personnel.

**** Contact Time:** "Wet time," also known as "contact time" or "dwell time," is the amount of time a disinfectant or antiseptic solution must remain wet and in direct contact with a target microorganism or on a surface to be effective. This time can range from 15 seconds to 10 minutes, which is the maximum time allowed by the US Environmental Protection Agency (EPA). The contact time is established by the product manufacturer.

**** Contamination:** The presence of potentially infectious pathogenic microorganisms on animate or inanimate objects or surfaces.

Contemporaneously: Originating, existing, or happening during the same period of time.

Continual: Repeated regularly and frequently in steady, rapid succession.

Continuous: Prolonged without interruption at any time.

Contract & Indirect Employees: These employees are not on the company's payroll and are not restricted by employment laws that apply to direct employees. Work details are defined in a contract agreed upon by the company and a contractor or third-party agency.

***** Covered ancillary services:** Items and services that are integral to a covered surgical procedure performed in an ASC as provided in §416.164(b), for which payment may be made under §416.171 in addition to the payment for the facility services. **[42 CFR 416.2]**

***** Covered surgical procedures:** Surgical procedures furnished before January 1, 2008, that meet the criteria specified in §416.65 and those surgical procedures furnished on or after January 1, 2008, that meet the criteria specified in §416.166. **[42 CFR 416.2]**

*** Deep Sedation/Analgesia:** A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

Decontamination: Any physical or chemical process that reduces the number of microorganisms on any inanimate object to render that object safe for subsequent handling.

Dental Anesthesiologist: A licensed DDS or DMD with specialized, hospital-based training in areas including pharmacology, internal medicine, emergency medicine, and pediatric and adult anesthesiology.

Dental Assistant: A dental team member who supports a dental operator in providing more efficient dental treatment. A dental assistant must graduate from an accredited dental assisting training program and earn certification or licensure as State law requires.

Direct Employee: A full- or part-time employee hired by a facility and paid directly through the facility's payroll. They are considered permanent employees because the intention is to work with them long-term rather than temporarily or as needed.

*****Direct Services** means services provided by the clinic's staff. **[42 CFR 491.2]**

**** Disinfectant:** A chemical agent used to kill viruses and bacteria on surfaces. It must be an EPA-registered disinfectant with bactericidal, tuberculocidal, and virucidal properties with specific claims and instructions for HIV and HBV.

**** EPA-Registered:** An EPA registration number signifies that a disinfectant and its claims have been reviewed and approved by the United States Environmental Protection Agency.

Equipment: The term "equipment" refers to the requirement that the specific item named must meet current performance standards according to the manufacturer's guidelines.

*****Extension Location:** A location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the rehabilitation agency. The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency. *[485.703 Condition]*

Facility Director: An individual that manages all aspects of a facility's operations. Their duties include budget management, facility planning, and building system maintenance.

Facility Leadership and Governing Body: These terms are interchangeable and refer to the person or group of people with full authority and responsibility for directing, overseeing, and controlling the facility's operations. Medicare uses the term "governing body," while non-Medicare facilities use the term "facility leadership." For both, the facility must define in policy the person or group of people that constitute the governing body or facility leadership.

Facility Safety Manual: A compilation of safety procedures and guidelines to follow in emergencies or unsafe situations.

***** Facility services:** For the period before January 1, 2008, services that are furnished in connection with covered surgical procedures performed in an ASC, and beginning January 1, 2008, means services that are furnished in connection with covered surgical procedures performed in an ASC as provided in §416.164(a) for which payment is included in the ASC payment established under §416.171 for the covered surgical procedure. **[42 CFR 416.2]**

Frequent: Occurring or done on many occasions or in quick succession; happening often.

General Anesthesia: A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Governing Body and Facility Leadership: These terms are interchangeable and refer to the person or group of people with full authority and responsibility for directing, overseeing, and controlling the facility's operations. Medicare uses the term "governing body," while non-Medicare facilities use the term "facility leadership." For both, the facility must define in policy the person or group of people that constitute the governing body or facility leadership.

**** Healthcare-Associated Infection (HAI):** An infection acquired by patients while they are receiving medical care, with confirmation of diagnosis by clinical or laboratory evidence. Infective agents may originate from endogenous or exogenous sources. HAIs, which are also known as nosocomial infections, may not become apparent until the patient has been discharged from the healthcare setting.

**** Immediate Use Steam Sterilization (IUSS):** An abbreviated process of steam sterilization of patient care instruments (or devices) for immediate use.

Immediately Available: Accessible (clinician and equipment) without any delay or waiting period. Examples include the physical presence of the health care professional in the facility to assess, evaluate, and provide care to a patient; a supervising physician is physically accessible and able to attend to the patient, without any delay, to address any situation requiring a supervising physician's services; and, 1) dedicated to the facility when on duty, 2) unencumbered by conflicting duties or responsibilities, 3) responding without delay when notified.

****Infection:** The invasion and multiplication of microorganisms in body tissues that cause cellular injury and clinical symptoms.

Instrument: Any tool, device, or apparatus used in medicine for the purpose of diagnosing, preventing, treating, or alleviating illness or injury. It encompasses a wide range of items, from simple tools like stethoscopes to complex machines like MRI scanners. Medical instruments can be used to examine the body, record physiological processes, administer treatments, or perform surgical procedures.

Intraoperatively: The intraoperative phase extends from the time the patient is admitted to the operating room to the time of anesthesia administration, the performance of the surgical procedure, and until the client is transported to the recovery room or post-anesthesia care unit (PACU).

**** Instructions for Use (IFUs):** Specific, detailed instructions provided by the manufacturer. IFUs for medical devices detail the steps required for cleaning, disinfection, and sterilization that are compatible with that device. Products approved for use in cleaning, disinfection, and sterilization will have specific IFUs to follow (e.g., dilution ratio and contact time) to ensure the product's efficacy.

Legally Qualified: Being in compliance or accordance with specific requirements or conditions. Is qualified under the applicable local, State or Federal law to hold the position for which he or she holds and has met the qualifications of the position.

Log: A written record of performance, events, or day-to-day activities. It is similar to a register, which is a written record containing regular entries of items or details.

Examples:

- On any day that controlled substances are administered, the controlled substance inventory and control record (log/register) must be updated as appropriate to reflect controlled substances administered, received, wasted, and currently stored by two licensed healthcare professionals. (6-D-2)
- A written record (log/register) of all operative cases is maintained by the facility. (8-L-1)

Major Blood Vessels: A group of critical arteries and veins including the aorta, coronary arteries, pulmonary arteries, superior and inferior vena cava, pulmonary veins, and any intra-cerebral artery or vein.

**** Mechanical (Physical) Indicator:** Monitors (embedded into the sterilization equipment) that register, record, and report parameters for each cycle (time in use, the temperature achieved, and the pressure attained in the chamber). The information attained through the gauges and/or printouts provides evidence the sterilization system has met the set parameters (or has not, and there is a need for corrective action).

Medical Director: The clinician responsible for overall oversight of the facility.

***** Medical Staff:** The organized body of licensed physicians and other healthcare providers who are permitted by law and through credentialing and privileges granted by the facility leadership to provide medical care within the facility. The medical staff includes physicians, surgeons, specialists, CRNAs, NPs, PAs, and allied health professionals, as identified in facility policy.

*** Minimal Sedation:** A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

*** Moderate Sedation/Analgesia (“Conscious Sedation” or “Procedural Sedation”):** A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

*** Monitored Anesthesia Care (“MAC”)** does not describe the continuum of depth of sedation; rather, it describes “a specific anesthesia service performed by a qualified anesthesia provider, for a diagnostic or therapeutic procedure.” Indications for monitored anesthesia care include “the need for deeper levels of analgesia and sedation than can be provided by moderate sedation (including potential conversion to a general or regional anesthetic).

National Fire Protection Association (NFPA) Business Occupancies, 2021 <https://www.nfpa.org/news-blogs-and-articles/blogs/2021/05/07/occupancy-classifications-and-model-codes>

- 1) **Business Occupancy** is an occupancy used for the transaction of business other than mercantile (engaged in commerce) This includes clinics.
- 2) **Ambulatory Health Care Occupancies** are occupancies used to provide services or treatment simultaneously to four or more patients that provide, on an outpatient basis, one or more of the following:
 - a. Treatment for patients that renders the patient's incapable of taking action for self-preservation under emergency conditions without the assistance of others
 - b. Anesthesia that renders patients incapable of taking action for self-preservation under emergency conditions without the assistance of others
 - c. Emergency or urgent care for patients who, due to the nature of their injury or illness, are incapable of taking action for self-preservation under emergency conditions without the assistance of others

Examples include Day Surgery, Dentists' Offices, oral surgery with sedation, and Endoscopy Centers.

***** Nurse Practitioner (NP):** A person who is currently licensed to practice in the State and meets the applicable State requirements governing the qualifications of nurse practitioners. And meets at least one (1) of the following conditions:

- 1) Is certified as a practitioner by a recognized national certifying body that has established standards for nurse practitioners and possesses a master's or doctoral degree in nursing practice or
- 2) Has satisfactorily completed a formal one (1) academic year educational program that:
 - i. Prepares registered nurses to perform an expanded role.
 - ii. That includes at least four (4) months (in the aggregate) of classroom instruction and a component of supervised clinical practice.
 - iii. Awards a degree, diploma, or certificate to persons who successfully complete the program.
- 3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role) that does not meet the requirements identified above in paragraph 2, and the Nurse Practitioner has been performing an expanded role in the delivery of care for a total of 12 months during the 18-month period immediately preceding the effective date of the subpart.

Nurses Note: Documentation that provides a record of nursing care provided to a patient, family, or community.

Office Surgery: Refers to invasive procedures performed under anesthesia or sedation in an outpatient provider's office or other non-hospital setting.

Oral Maxillofacial Surgeon (OMF): A medical doctor who is specifically trained in maxillofacial surgery. Because of the focus on the oral area, typically, maxillofacial surgeons attend dental school for four years after receiving their bachelor's degree.

Patient Safety Data Reporting (PSDR): A form of quality control performed by QUAD A accredited facilities within the outpatient setting. Those participating in the data reporting process create a system-

wide culture of clinical quality and demonstrate the positive results of accreditation. PSDR reporting is required for QUAD A facilities participating in Office-Based Surgical, Office-Based Procedural, Oral Maxillofacial Surgery, Pediatric Dentistry, International Surgical, or Medicare ASC programs. Reporting PSDR data is required quarterly, including physician case review. Results of the physician case reviews are discussed during Peer Review meetings.

Pediatric Advanced Life Support (PALS): A course that trains and certifies participants in a set of clinical guidelines for the urgent and emergent treatment of life-threatening cardiovascular conditions in children that will cause or have caused cardiac arrest using advanced medical procedures, medications, and techniques through didactic and hands-on skills return demonstration sessions. It builds on the foundation of lifesaving basic life support (BLS) skills. It reflects science and education from the *American Heart Association Guidelines Update for CPR and Emergency Cardiovascular Care (ECC)*. The course is approved by the American Heart Association (AHA) or an identical content course that conforms to the current AHA Guidelines.

Pediatric Dentist: A licensed dentist in the state where the dentist practices and who has satisfactorily completed:

- 1) Four (4) years of dental school.
- 2) Two (2) additional years of residency training in dentistry for infants, children, teens, and children with special needs.
- 3) A minimum of 24 months in an advanced education program accredited by the Commission on Dental Accreditation of the American Dental Association. Such programs “must be designed to provide special knowledge and skills beyond the Doctor of Dental Surgery (DDS) or Doctor of Medicine in Dentistry (DMD) training.
- 4) A curriculum of an advanced program provides the dentist with the necessary didactic background and clinical experiences to provide comprehensive primary oral health care and the services of a specialist.

Pediatric Patients: In Florida, pediatric patients are defined as those who are 13 years of age or under. For all other QUAD A facilities, pediatric patients are defined by facility policy and procedure, which must consider age, BMI or weight, special needs, risk categories, surgery, facility equipment, and capability, unless otherwise defined by the state.

**** Peel Pouch:** A sterilization pouch (or peel pack) is a disposable package validated for use in a sterilizer to allow penetration of the sterilant to the items placed inside. After sterilization, peel pouches maintain the sterility of the processed item(s) during storage and until needed for use. Pouches are designated as Class II medical devices and may be self-sealing or heat-sealing. “Double pouching” should only be performed if validated for the specific type of pouch and when the manufacturer’s instructions for use provide the method of packaging and the sterilization parameters.

Peer: An individual(s) of the same professional discipline and specialty who possesses sufficient training and experience to render judgment on the clinical circumstances under review.

Peer Review: The task of physicians holding one another to the ethical standards of their profession and maintaining the administration of patient safety and quality of care consistent with optimal standards of

practice. The American Medical Association (AMA) publishes information regarding the peer review process and describes the composition of the Peer Review Committee as follows:

*Peer review is conducted in good faith **by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review** to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that are convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.*

What is Peer Review? <https://www.amwa-doc.org/what-is-peer-review/>

Percutaneous endovascular intervention: A procedure performed without an open direct visualization of the target vessel requires only needle puncture of an artery or vein, followed by insertion of catheters, wires, or similar devices, which are then advanced through the blood vessels using imaging guidance. Once the catheter reaches the intended location various maneuvers to address the diseased area may be performed which include, but are not limited to, injection of contrast for imaging, treatment of vessels with angioplasty, atherectomy, covered or uncovered stenting, intentionally occluding vessels or organs (embolization), and delivering medications, radiation, or other energy such as laser, radiofrequency, or cryo.

Personnel: Everyone employed (including volunteers) at a facility, including both direct and indirect (contract) employees who provide care, treatment, or services to patients. The terms “personnel” and “staff” are synonymous.

**** Personal Protective Equipment (PPE):** Protective equipment (e.g., masks, gloves, goggles, face shields, and gowns) for eyes, face, head, and extremities; protective clothing; respiratory devices; and protective shields and barriers designed to protect the wearer from injury and minimize exposure to hazards.

***** Physician:** Providers who medically diagnose patients, prescribe and manage medication, and supervise other medical staff. A licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO) legally authorized to practice medicine or surgery in the State in which the function is performed; and a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally authorized to practice dentistry by the State in which he/she performs such function and who is acting within the scope of his/her license and a Doctor of Podiatric Medicine

Physician Anesthesiologist: A medical doctor who has attained either a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) degree and has chosen to specialize in the field of anesthesiology and specializes in anesthesia care, pain management, and critical care medicine, and have the necessary knowledge to understand and treat the entire human body.

***** Physician Assistant (PA):** An individual who meets the applicable State requirements governing the qualifications for assistants to primary care physicians. And meets one of the following conditions:

- 1) The physician assistant is currently certified by the National Commission on Certification of Physician Assistants to assist physicians.

- 2) The physician assistant has satisfactorily completed a program for preparing physician's assistants that:
 - i. Was at least one (1) academic year in length.
 - ii. Consisted of supervised clinical practice and at least four (4) months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and
 - iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation.
- 3) The physician assistant has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements of paragraph (2) of this definition and assisted physicians for a total of 12 months during the 18-month period that ended on December 31, 1986.
- 4) Is licensed as a PA by the State in which the PA practices.

Polyclinic: An outpatient clinic that is a free-standing medical facility, designed to receive and undergo patients to necessary medical examinations and treatments, encompassing a minimum of two (2) different specialties which may include diagnostics, dental and Traditional Complimentary Alternative Medicine (TCAM) services, to patients that do not stay overnight.

Proceduralist: A licensed physician, usually a specialist or subspecialist, trained and qualified to perform diagnostic or therapeutic procedures. A licensed trained CRNA, NP and PA may also conduct selected procedures based on state law and scope of practice.

Procedural accreditation: This is intended for office-based facilities performing procedures in medical specialties including gastroenterology, urology/nephrology, gynecology, interventional radiology/vascular access, pain management, and dermatology. Procedures are performed by specialists including Gastroenterologists, Urologists/Nephrologists, Gynecologists, Pain Management Specialists, Dermatologists, or Interventional Radiologists/Vein Specialists, and may include minimally invasive procedures and approved minor surgical procedures (e.g. minor urological surgical procedures including circumcisions, vasectomies; minor dermatological procedures including mole/growth removal, minimally invasive gynecological surgeries as entered through the vagina, etc.).

Professional Appearance: relates to both the appearance of people and the appearance of the facility.

A healthcare provider's personal appearance must project professionalism and competence to engender trust in patients. A provider also conveys professionalism in how they communicate, how they express courtesy, body language, and what they wear. E.g., as professional healthcare providers, facility staff should appear clean and well dressed. The facility should appear clean, neat, and furnished for patients, staff, and visitor comfort.

Examples:

- As professional healthcare providers, facility staff should appear clean and well dressed. When interacting with patients and patient families, the facility staff should be friendly, knowledgeable, and culturally sensitive.

- The facility should appear clean, neat, and furnished for patients, staff, and visitor comfort

Progress note: An essential tool used in healthcare to document patient information, medical history, treatment plans, and progress throughout a patient's care. Progress notes are also a crucial communication tool among healthcare professionals, ensuring continuity of care and facilitating collaboration.

Promptly: Without delay; immediately

Public health agency: an official agency established by a State or local government, the primary function of which is to maintain the health of the population served by performing environmental health services, preventive medical services, and in certain cases, therapeutic services. **[485.703 Condition]**

Qualified: An individual who is qualified by education, training, licensure/regulation (when applicable, also includes registration and certification), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Random Sample: An unbiased representation of a group.

Example:

- For PSDR reporting, QUAD A recommends entering the first case as performed each month to obtain a random sample of cases entered into the quarterly reporting system. If no cases are performed in a given month, any other case can be selected at random from the period

Rehabilitation agency - An agency that:

- Provides an integrated interdisciplinary rehabilitation program designed to upgrade the physical functioning of handicapped disabled individuals by bringing specialized rehabilitation staff together to perform as a team; and
- Provides at least physical therapy or speech-language pathology services.

[485.703 Condition]

Routine: A habit or sequence that does not vary; things that must be done on a regular basis.

***** Rural area** mean an area that is not delineated as an urbanized area by the Bureau of the Census. [42 CFR 491.2]

***** Rural health clinic:** a clinic located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases and meets all other requirements of this subpart. [42 CFR 491.2]

***** Secretary:** The Secretary of Health and Human Services, or any official to whom he/she has delegated the pertinent authority.

***** Shortage area:** a defined geographic area designated by the Department as having either a shortage of personal health services (under section 1302(7) of the Public Health Service Act) or a shortage of primary medical care manpower (under section 332 of that Act). **[42 CFR 491.2]**

Significant: Having or likely to have influence or effect; or of a noticeable or measurably large amount.

Examples:

- As determined by both the surgeon/proceduralist and anesthesia provider, the patient and procedural risk must be assessed pre-operatively. If this risk level is above a facility's defined threshold, then the patient should be referred to an alternative, safer facility for the operation.
- Current safe levels of ethylene oxide or glutaraldehyde exposure must be identified. Badge testing to maintain exposure under the threshold must be performed and monitored.

Staff: Anyone employed (part-time, full-time) at a facility, including both direct and indirect (contract) employees that provide care, treatment, or services to patients. The terms "personnel" and "staff" are synonymous.

**** Sterile:** The state of being free from all living microorganisms. In practice, it is usually described as a probability function (e.g., as the probability of a microorganism surviving sterilization being 1 in 1,000,000).

**** Sterilization:** A validated process that removes or destroys all viable microorganisms, including bacterial spores, to an acceptable sterility assurance level, usually 1 in 1,000,000. In a sterilization process, the presence of microorganisms on any individual item can be expressed in terms of probability (which, even though is a very low number, may never be zero).

Sufficient/sufficiently means enough to meet the needs of a situation or a proposed end. E.g., A hallway would be sufficiently wide if healthcare providers can wheel a patient in a gurney and all necessary medical equipment with the gurney in case of emergency.

Example:

- A hallway would be sufficiently wide if healthcare providers can wheel a patient in a gurney and all necessary medical equipment with the gurney in case of emergency. (3-F-4)

Supernatant fat: The fat that rises to the top and separates from other fluids or tissues during processes such as liposuction. In the context of cosmetic surgery, it is important to manage the amount of supernatant fat removed to ensure patient safety and compliance with medical regulations.

Surgeon: A licensed physician trained and qualified to perform surgical procedures.

***** Surgery** is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery is also the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue, which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system is also considered to be surgery. (This does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous when ordered by a physician.) Surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

- 1) **Major surgery** is an invasive operative procedure where one (1) or more of the following occurs:
 - a. A body cavity is entered.
 - b. A mesenchymal barrier is crossed.
 - c. A fascial plane is opened
 - d. An organ is removed
 - e. Normal anatomy is operatively altered
- 2) **Minor Surgery** is an invasive operative procedure in which only skin, mucous membranes, or superficial connective tissue is manipulated.

*** Supervision

1. **Direct Supervision:** The supervising physician must be immediately available if needed, meaning physically present in the facility, and prepared to immediately conduct hands-on intervention if needed. However, the physician does not need to be in the room throughout the performance of the service.
2. **General supervision:** The service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and maintain the necessary equipment and supplies is the physician's continuing responsibility.
3. **Personal supervision:** A physician must be present in the room during the procedure.

**** Surgical Site Infection (SSI):** An infection at the site of a surgical incision. The SSI may be superficial, deep, or extend to organs. Patients should be monitored for SSIs for thirty (30) days after surgery or procedures or three-hundred and sixty-five (365) days after implant placement.

Track and Trend: Track, as in keep track of, is to follow specific record(s) or specific types of information over a defined period. To trend means to follow the general movement over time of a statistically detectable change. Tracking and trending are commonly used together which means a trail of data is followed to identify changes in outcomes over time.

Examples:

- Each facility's written QI program must follow identified records or types of information over a lengthy period of time to identify changes. Based on those changes, or lack thereof, the facility must evaluate and resolve problems, then adjust the identified records or types of information as appropriate.
- Each facility's risk management program must perform an annual risk assessment. This assessment should cover risks as related to patients and staff by medication management, fall hazards, infection control, equipment safety, patient risk resulting from long term conditions, and nutrition if any food or beverage services are available to patients. The trends of these risks across the years should be noted.
- Adverse events are to be noted and discussed during periodic peer review meetings.
- All adverse events should be looked at cumulatively.

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10-D-0	Business Associate Contracts https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html Covered Entities and Business Associates https://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html Model BAA https://www.hhs.gov/sites/default/files/model-business-associate-agreement.pdf HIPAA Business Associate Agreement https://www.hipaajournal.com/hipaa-business-associate-agreement/ QUAD Sample BAA https://6276684.fs1.hubspotusercontent-na1.net/hubfs/6276684/Applications/HIPAA%20BAA%202022%20122021-2.pdf
11-C-5	Guidelines for Teaching Physicians, Interns, & Residents www.cms.gov/files/document/guidelines-teaching-physicians-interns-and-residents.pdf
11-C-7	American Board of Medical Specialties, Verify Certification https://www.abms.org/board-certification/verify-certification/ Health Guide USA, Medical License Lookup https://www.healthguideusa.org/medical_license_lookup.htm National Council of State Boards of Nursing (NCSBN) Nurse Licensure Look Up https://www.nursys.com/
11-C-9	What's a Nurse Practitioner (NP)? https://www.aanp.org/about/all-about-nps/whats-a-nurse-practitioner American Association of Physician Assistants https://www.aapa.org/career-central/become-a-pa/
11-C-10	AMA Code of Ethics https://code-medical-ethics.ama-assn.org/principles
11-D-8	American Society of Dentist Anesthesiologists: Parameters of Care, 2018 https://pmc.ncbi.nlm.nih.gov/articles/PMC6148692/ Guidelines for the Use of Sedation and General Anesthesia by Dentists, 2016 https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/ada_sedation_use_guidelines.pdf?rev=313932b4f5eb49e491926d4feac00a14&hash=C7C55D7182C639197569D4ED8EDCDDF6 Parameters of Care: Clinical Practice Guidelines for Oral and Maxillofacial Surgery, Anesthesia in Outpatient Facilities (AAOMS ParCare 2023) https://aaoms.org/wp-content/uploads/2024/08/parcare_anesthesia_in-outpatient.pdf
11-G-2	US Legal Direct Supervision Law and Legal Definition https://definitions.uslegal.com/d/direct-supervision/
11-H-3	OSHA https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1020 Health Information Privacy https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html ADA Title 42 Section 12101 Equal Opportunity for Individuals with Disabilities

Standard ID	Reference
	https://www.ada.gov/law-and-regs/ada/
11-H-5	ADA Title 42 Section 12101 Equal Opportunity for Individuals with Disabilities https://www.ada.gov/law-and-regs/ada/ (Refer to Section 12112(d) Medical Examinations and Inquiries).
11-H-10	Healthcare Personnel Vaccination Recommendations www.immunize.org/wp-content/uploads/catg.d/p2017.pdf OSHA Hepatitis B Vaccination Protection https://www.osha.gov/publications/bbfact05 OSHA Hepatitis B Declination (Mandatory) www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030AppA Hepatitis B Vaccination: Information for Healthcare Providers https://www.cdc.gov/vaccines/vpd/hepb/hcp/
11-H-11	OSHA Hepatitis B Vaccination Protection https://www.osha.gov/publications/bbfact05 OSHA Hepatitis B Declination (Mandatory) www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030AppA Hepatitis B Vaccination: Information for Healthcare Providers https://www.cdc.gov/vaccines/vpd/hepb/hcp/

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