GAHAR ACCREDITATION GUIDE

Publisher:
General Authority for Healthcare Accreditation and Regulation.

Edition 2026

GAHAR ACCREDITATION GUIDE

Publisher: General Authority for Healthcare Accreditation and Regulation.
Edition: first edition 2026.

Edition 2026

this page intentionally left blank

Contents

Acknowledgments

GAHAR Accreditation Guide Development Committee

Prof. Dr. Sayed El Okda
Professor of Occupational Health and Environment, Faculty of Medicine, Ain Shams University.

Dr. Khalid Omran
International Quality and Patient Safety Consultant

Dr. Ihab Shehad
MD, GAHAR lead surveyor.

Dr. Eman Darwish
GAHAR Lead Surveyor.

Eng. Marwa Eisawy
GAHAR Lead Surveyor.

Dr.Metwally Mohamed Metwally
GAHAR Lead Surveyor.

Dr. Eman El-sayed
GAHAR Lead Surveyor.

Dr. Nahla Badr
GAHAR Lead Surveyor.

Prof. Dr. Walaa Abdel-Latif
Professor of Medical Microbiology and Immunology, Faculty of Medicine, Ain Shams University, IPC Consultant

Standards Research and Development Department at GAHAR

Dr. Reham Magdy
Standards Development Team Member

Dr. Hosam Khater
Standards Development Team Member

Dr. Muhammad Lotfy
Standards Development Team Member

Dr. Walaa Abo-Elela
Head of Department

GAHAR Surveyors' Affairs Department

Dr. Hend el Hussneiy
Head of Department

Special thanks to the GAHAR departments that participated in the revision of related rules and policies

Healthcare Facilities Accreditation and Registration Department

Accreditation and Registration of Medical Professions Department

Surveyors Affairs Department

Quality and Organizational excellence Department

Healthcare Regulation Department

Dr. Mohammed El says
Acting Chief Executive Director

Directed & Designed by
Eng. Ahmed Hammad

GAHAR Board Members

Dr. Aya Nassar
Vice Chairman, GAHAR

Dr. Khaled Omran
Board member, GAHAR

Prof. Dr. Wael El-Darandaly
Board member, GAHAR

Dr. Eman El-Shahat
Board member, GAHAR

Prof. Dr. Mahi Al Tehewy
Board member, GAHAR

Prof. Dr. Sayed El Okda
Board member, GAHAR

Prof. Dr. Walaa Abdel-Latif
Board member, GAHAR

Prof. Dr. Ahmed Taha
Chairman, GAHAR

Section 1

INTRODUCTION AND FRAMEWORK

Overview of the Accreditation Process

The GAHAR Accreditation Guide has been developed to support hospitals seeking accreditation from the General Authority for Healthcare Accreditation and Regulation (GAHAR). It provides a clear, structured, and comprehensive framework that guides hospitals through each stage of the accreditation journey.

The accreditation process begins with survey preparedness activities, during which hospitals align their systems, teams, and documentation with GAHAR standards. This is followed by an official onsite survey visit, conducted by GAHAR, to evaluate the hospital's compliance with accreditation standards.

Following the onsite survey, the post-survey activities focus on sustaining performance and promoting a culture of continuous quality improvement. These activities include corrective action plans, and unannounced audit visits to monitor ongoing compliance with GAHAR standards. Together, they ensure hospitals maintain accreditation, implement necessary improvements, and deliver consistent, high-quality care throughout the accreditation period.

This guide applies to hospitals as whole organizations seeking accreditation from GAHAR. It provides a structured pathway for achieving and maintaining accreditation while promoting standardization and consistency across the national healthcare system.

this page intentionally left blank

About Us

The General Authority for Healthcare Accreditation and Regulation (GAHAR) is an independent governmental authority. GAHAR was established under Law No. 2 for the year 2018 pertaining to the Universal Health Insurance System that ensures the provision of healthcare services in different health facilities in accordance with the highest quality and safety standards.

Role of GAHAR

The General Authority for Healthcare Accreditation and Regulation (GAHAR) is the national authority responsible for developing, issuing, and ensuring the implementation of healthcare accreditation standards across Egypt. Its primary role is to maintain the quality and safety of healthcare services, drive continuous improvement, and regulate the healthcare sector based on internationally recognized standards.

GAHAR's standards are developed in accordance with the ***Principles for the Development of Health and Social Care Standards*** issued by the International Society for Quality in Health Care External Evaluation Association (ISQua-EEA). These standards reflect core functions shared by all healthcare organizations and are built on evidence-based practices and a patient-centered approach.

Through its accreditation system, GAHAR helps healthcare facilities enhance performance by identifying strengths, addressing areas for improvement, and promoting safer care. Beyond evaluation, GAHAR supports institutions in developing their internal processes and managing risks through proactive, scientific methods aimed at prevention and improvement.

GAHAR Accreditation Standards

- GAHAR Handbook for Hospital Standards
- GAHAR Handbook for Primary Healthcare Standards
- GAHAR Handbook for Clinical Laboratories Accreditation Standards
- GAHAR Handbook for Physical Therapy Accreditation Standards
- GAHAR Handbook for Ambulatory Healthcare Accreditation Standards
- GAHAR Handbook for Diagnostic and Therapeutic Radiology Accreditation Standards
- GAHAR Handbook for Mental Healthcare Accreditation Standards
- GAHAR Handbook for the Accreditation Standards of Convalescent / Long-Term Healthcare and Medical Wellness Services

Mission

Commitment to ensuring the quality of healthcare services and its continuous improvement in the Arab Republic of Egypt, and affirming trust in its outcomes at national, regional, and international levels through issuance and development of internationally recognized national quality standards, supporting their implementation, accrediting healthcare facilities accordingly, and continuous monitoring to achieve excellence and sustainability.

Vision

To be a pioneering national authority, well-recognized regionally and internationally, in ensuring the quality of healthcare services and its sustainability.

Governing Values

Excellence and Sustainability	Governance	Trust
Respect	Credibility	Continuous Improvement
Innovation	Equity	Collaborative Work

this page intentionally left blank

Section 2

GAHAR ACCREDITATION RULES

this page intentionally left blank

1. Eligibility Criteria for GAHAR Hospital Accreditation Survey:

Hospitals can apply for accreditation if the following eligibility criteria are met:

- Compliance with licensure requirements for licensing the hospital as mandated by laws and regulations that cover all the services it provides, where applicable.
- The hospital ensures the validity of the submitted documents.
- The Agreement must be signed by the facility manager and stamped with the facility's official seal.
- This guide is applied to the hospitals (as a whole organization)—including all healthcare facilities that provide care for patients with a length of stay of 24 hours or more—seeking to be accredited by the General Authority for Healthcare Accreditation and Regulation (GAHAR) that include:
  - Ministry of Health and Population hospitals
  - Military hospitals
  - Police hospitals
  - Sectorial hospitals
  - Private hospitals
  - Charity hospitals
  - Academic hospitals
  - Teaching hospitals
- This guide is not applied to the following healthcare facilities:
  - Day-care hospitals
  - Long-term care facilities
  - Mobile hospitals and medical caravans
  - Non-allopathic systems of medicine
  - Alternative medicine streams
  - Wellness centers
  - Virtual hospitals
- The hospital has been open and operating, either fully or partially, for at least six months.

Note:

If GAHAR, in its reasonable judgment, determines that an applicant does not meet the eligibility criteria for the Hospital Accreditation Program, it may:

- Reject the application

- Discontinue the accreditation process,

or

- Redirect the applicant to a more suitable accreditation program based on the healthcare facility's scope and the Board of Directors' decisions.

The hospital will be formally notified of GAHAR's decision.

2. Rules and Requirements for a GAHAR Accreditation Survey

- Compliance with current relevant laws, regulations, licensure requirements, and their updates.
- Compliance with the GAHAR Safety Requirements for hospitals, to ensure the safety of the patients/patients' families, visitors, and staff.
- The accredited hospital has to inform GAHAR of any change in the field of services provided (adding a new service, cancelling an existing service, or increasing the volume of an existing service by more than 20%) in writing to the e-mail reg@gahar.gov.eg within three months after the actual implementation of this change.
- The hospital shall ensure the validity of the documents and data provided at all stages of the accreditation process. If there is evidence that the submitted documents are proven to be inaccurate, the hospital is at risk for rejection of accreditation.
- The accreditation may be withdrawn or at risk of rejection if there is evidence that the facility has falsified or withheld or intentionally misled the information submitted to GAHAR.
- The facility is not permitted to use GAHAR's certificate or logo in a misleading manner.
- GAHAR shall inform the facility about the accreditation decision within a period not exceeding 30 working days starting from the date of completion of the survey visit.
- GAHAR has the right to publish the end result of the survey visit, accreditation suspension, or rejection, according to the requirements.
- The accredited hospital has to communicate all sentinel events to GAHAR within 48 hours of the event or becoming aware of the event via email notification using the following link: Sentinel.Event@gahar.gov.eg. The root cause analysis shall be submitted no later than 45 days starting from the date of the occurrence or its notification with the appropriate corrective plan to prevent/reduce its recurrence according to the nature of the event.

Applying for GAHAR Accreditation Survey

A hospital seeking GAHAR accreditation begins by:

- Log in to the online platform (Portal) of the General Authority for Health Accreditation and Regulation to register the data of the hospital via the following link: https://eportal.gahar.gov.eg.
- Create a new account using an institutional email account for hospital use; personal email addresses are not permitted.
- Choose the type of service, type of facility, and user's data.
- Complete the basic data of the application (the electronic registration application).
- Complete the contact information, the applicant's data, and the healthcare facility data, and upload the required documents.
- Print the application request, fill in the declaration form, and get it signed by the responsible person, sealed with the facility's seal, re-upload, and click on "Issue application."
- You can browse the system anytime to follow up on the status of the request and implement the required requests of GAHAR.
- GAHAR will determine the survey financial fees, and bank account details will be shared.
- The hospital will make the payment to the central bank of Egypt on the bank account, and it will send the receipt back via email.
- Register healthcare professionals with the ratio approved by the accreditation supreme committee before the evaluation visit.
- An appointment for the survey visit will be determined for the hospital.
- GAHAR's surveyors' team will evaluate your hospital according to the GAHAR Handbook for Hospital Accreditation Standards.
- The survey report is submitted to the accreditation supreme committee to review and decide based on accreditation decision rules.
- The hospital is notified of the decision of the accreditation supreme committee. The hospital has 15 days to submit an appeal. If no appeal is submitted, the chairman of GAHAR approves the decision, and a final certificate is issued.

For hospitals seeking GAHAR reaccreditation:

- GAHAR informs the accredited hospital via an email sent by the General Administration of Healthcare Facilities Accreditation and Registration (reg@gahar.gov.eg) within six months prior to the expiration of the previous accreditation period, requesting the hospital to

confirm its decision regarding the renewal or cancellation of its accreditation status.

- The facility's information is then updated, and the hospital must follow the same steps outlined above for applying for a GAHAR accreditation survey as followed during the initial application for accreditation.

Healthcare Professionals Registration

Healthcare Professionals (HCPs) Registration

- HCPs registration aims to ensure that healthcare service providers are able to perform their work properly based on their qualifications and experience within the scope of medical services for the registered or accredited facility in order to improve the quality of healthcare services provided to the community.
- Registration of healthcare professionals ensures that the appropriate medical team is present to provide health services at the facility registered or accredited by GAHAR.
- After completing the application for the GAHAR Accreditation Survey, the health care facility must proceed with the Healthcare Professionals (HCPs) Registration process.
- The program includes the registration of members for the following medical professions:
  - Physicians
  - Dentists
  - Pharmacists
  - Physiotherapists
  - Nurses
  - Nursing technicians
  - Health technicians
  - Chemists and physicists
  - Veterinary doctors

Steps and procedures for registration for members of the medical professions

- Apply to register your facility's healthcare professionals via the e-mail HCP@gahar.gov.eg
- All required documents for medical professionals must be submitted to the General Administration of Healthcare Professionals Registration, including the following:
  - National ID card
  - Graduation certificate and any postgraduate academic degrees
  - Valid professional practice license
  - Syndicate membership card (mandatory for all healthcare professionals, except Health technicians, Chemists and physicists
  - Equivalency certificate issued by the Supreme Council of Universities, if applicable

- Complete the excel attached to you in response to your request and upload the required attachments of healthcare professionals working at your facility. We kindly request adherence to the specified timeframe mentioned in the email sent to you.
- The attached documents will be reviewed, and the registration procedure will be completed.
- The codes for the medical professionals will be sent to you as soon as they are issued.

General Rules of Suspension and Cancellation of the Accreditation

A. Accreditation may be suspended (for a period not exceeding 6 months) if:

- The hospital data in the application form does not match its status upon evaluation visit.
- Sentinel events related to the safety of patients, healthcare providers, or visitors that have been reported to GAHAR while root cause analysis with the appropriate corrective plan has not been submitted within 45 days starting from the date of the occurrence or its notification.
- GAHAR has not been notified of any changes in the scope of services provided (e.g., adding a new service, cancelling an existing service, or increasing the volume of an existing service by more than 20%) within three months after the actual implementation of this change.
- Incompliance with the registration of the ratio required of the total number of healthcare professionals before the evaluation visit of reaccreditation.
- The hospital fails to pass focus surveys in case of conditioned accreditation.
- The hospital fails to submit corrective action plans in case of the presence of not met EOC(s).
- The hospital fails to comply with GAHAR circulars when applicable.

B. Accreditation may be withdrawn or at risk of rejection if:

- The facility fails to pass focus surveys in case of conditioned accreditation.
- GAHAR team discovered any falsification, withhold or intentionally misleading the information submitted during or after the survey visit, or it is proven that the attached and submitted documents are inaccurate.
- The facility prevents GAHAR regulatory team/inspectors from doing their duties, such as refusal or preventing them from reviewing documents and data related to the scope of their duties.
- The facility refuses to meet the auditors' team or GAHAR surveyors in the announced / unannounced evaluation visits.
- A legal document issued by an administrative agency or Supreme Court rules against the facility either by permanent or temporary closure.
- Moving the facility from its actual place mentioned in the application form, or when the facility is demolished, reconstructed, or rebuilt without any pre-notification to GAHAR.
- Exceeding the period prescribed for suspension of accreditation without correcting the reasons for this suspension.

- The Hospital fails to submit corrective action plans in case of the presence of not met EOC(s).
- The Hospital fails to comply with GAHAR circulars when applicable.

Scoring Guide

- During the survey visit, each standard is scored for evidence of compliance (EOC).
- These are mathematical rules that depend on the summation and percentage calculation of scores of each applicable EOC as follows:
  - **Met** when the hospital shows 80% or more compliance with requirements during the required lookback period with a total score of 2.
  - **Partially met** when the hospital shows less than 80% but more than or equal to 50% compliance with requirements during the required lookback period with a total score of 1.
  - **Not met** when the hospital shows less than 50% compliance with requirements during the required lookback period with a total score of 0.
  - **Not applicable** when the surveyor determines that the standard requirements are out of the organization's scope (the score is deleted from the numerator and denominator).
  - While most EOCs are independent, stand-alone units of measurement that represent the structure, process, and/or outcome, few EOCs are dependent on each other. Dependence means that compliance with one EOC cannot be achieved (or scored) without ensuring compliance with other EOCs.
- **Scoring of each standard**
  - **Met:** when the average score of the applicable EOCs of this standard is 80% or more.
  - **Partially met** when the average score of the applicable EOCs of this standard is less than 80% or not less than 50%.
  - **Not met** when the average score of the applicable EOCs of this standard is less than 50%.
- **Scoring of each chapter**
  - Each chapter is scored after calculating the average score of all applicable standards in this chapter.

GAHAR Accreditation Decision Rules

A hospital can achieve accreditation by demonstrating compliance with certain accreditation decision rules. These rules mandate achieving certain scores on a standard level, chapter level, and overall level, as the accreditation decision is composed of four decisions.

1st Decision: Status of Accreditation for a hospital (3 years).

- Overall compliance of 80% or more, and
- Each chapter should score not less than 70%, and
- Only one whole standard is scored as not met, and
- No single not met GSR standard.

2nd Decision: Status of Conditioned Accreditation for a hospital (2 years).

- Overall compliance of 70% to less than 80%, or
- Each chapter should score not less than 60%, or
- Up to one standard not met per chapter, and
- No single not met GSR standard.

3rd Decision: Status of Conditioned Accreditation for a hospital (1 year).

- Overall compliance of 60% to less than 70%, or
- Each chapter should score not less than 50%, or
- Up to two standards not met per chapter, and
- No single not met GSR standard.

4th Decision: Rejection of Accreditation

- Overall compliance of less than 60%, or
- One chapter scored less than 50%, or
- More than two standards not met per chapter, or
- Not met GSR standard.

Hospitals having a status of accreditation or conditioned accreditation with elements of noncompliance are requested to:

- Submit a corrective action plan for unmet EOCs and standards within 90 days for 1st decision, 60 days for 2nd decision, and 30 days for 3rd decision to the email reg@gahar.gov.eg.
- Apply and pass the accreditation survey in 2 years for 2nd Decision and 1 year for 3rd Decision.

Look-back Period

- Surveyors are required to review standards requirements and evaluate organization compliance with them over a lookback period.
- Look-back period: It is the period before the survey visit during which any hospital is obliged to comply with the GAHAR accreditation standards. Failure to comply with this rule affects the accreditation decision.
- Look-back period varies from one hospital to another, depending on the hospital's accreditation status.

A. A hospital seeking accreditation will:

- Comply with GAHAR Handbook for Hospital Accreditation Standards as applicable for at least four months before the actual accreditation survey visit.

B. A hospital seeking reaccreditation:

- For GAHAR-accredited hospitals, compliance with the GAHAR Handbook for Hospital Accreditation Standards from receiving the approval of the previous accreditation till the next accreditation survey visit.

GAHAR Technical Support for Healthcare Facilities

GAHAR provides technical support visits through the Technical Support for Healthcare Facilities Department prior to accreditation to ensure that healthcare facilities are well-prepared for the accreditation process. These visits are conducted upon request by healthcare facilities. The purpose of these visits is to help facilities build their capacity to conduct effective self-assessments, identify performance gaps, and implement corrective actions in alignment with accreditation standards. These visits aim to promote a culture of self-assessment, ensure proper understanding of the standards and the Self-Assessment Tool (SAT), support facilities in recognizing areas of weakness, and assist in the development of corrective action plans.

GAHAR conducts several types of technical support visits (field visits) to support healthcare facilities in their accreditation journey, including General Visits, Follow-up Visits, Focused Follow-up Visits, and Tailored Visits. Technical support visits follow the same activities described in the 'Onsite Survey Activities Explanation' section that are outlined below, but without the use of patient tracers or system tracers. the GAHAR Self-Assessment Tool for Hospital Accreditation Standards will be used during these visits, which are available on GAHAR website. .For more information, visit GAHAR Technical Support for Healthcare Facilities webpage. To request a visit, fill out the visit form available on the website and submit it via email to sap@gahar.gov.eg.

GAHAR reviews the Self-Assessment Tool (SAT) and the corrective action plans submitted by hospitals and provides constructive feedback to help them reach the required performance level.

Section 3

SURVEY PROCESS AND METHODOLOGY

this page intentionally left blank

A. Accreditation onsite - Survey Preparedness

Survey Scheduling and Survey Agenda

The GAHAR Surveyors' Affairs Department is responsible for scheduling healthcare facility surveys. Following the completion of the application for GAHAR Accreditation Survey and the Healthcare Professionals Registration process, the Surveyors' Affairs Department determines the date of the survey visit at least two weeks in advance and sends the surveyors' bios to the hospital, allowing them to review the information and identify any potential conflicts of interest.

The Surveyors' Affairs Department also communicates the survey agenda to the designated healthcare facility representatives seven days prior to the survey visit.

Each healthcare facility survey involves a team of two to four surveyors, who spend approximately one to four days on-site, depending on the hospital's scope, size, and complexity of services. The duration of the visit and the corresponding schedule are determined accordingly.

For re-accreditation visits, scheduling is determined within a timeframe close to the end of the existing accreditation period.

Details regarding the scheduling, cancellation, or postponement of survey visits are outlined in the relevant section of this guide.

The hospital shall provide documented approval from GAHAR for any accompanying observers may attend the survey visit (maximum of two), including their names and bios and shall notify the Surveyors' Affairs Department via email at Surv.affairs@gahar.gov.eg.

Accompanying Observer: An individual from the corporate body or the Central Administration of Healthcare Quality who attends the survey for observation purposes only and does not participate in any survey activities.

Conflict of Interest

GAHAR requires all surveyors to sign confidentiality and conflict of interest agreements.

If the hospital identifies any conflict of interest after receiving the surveyors' bios, it must notify the Surveyors' Affairs Department via email at Surv.affairs@gahar.gov.eg. The hospital is expected to maintain professional standards in dealing with surveyors. The hospital is expected to report to GAHAR if there is a conflict of interest between a surveyor and the hospital that could affect any of the following: Integrity, objectivity, professional competence, confidentiality, and respect

In addition, the following actions and behaviors that could create a conflict of interest should be considered:

- Accepting gifts or monetary compensation from the surveyed healthcare facility
- Previous employment or consultancy with the healthcare facility within the past five years
- The surveyors are unreachable after the on-site survey, and it's not allowed to provide their personal contact information.

Throughout the accreditation process, GAHAR Surveyors' affairs department is available to answer any queries the hospital might have through visits.app@gahar.gov.eg.

Travel Arrangements

GAHAR will coordinate and arrange all logistics related to hotel accommodation and transportation prior to the survey visit. GAHAR is committed to ensuring that surveyors are provided with appropriate accommodation and reliable transportation throughout the duration of the survey. In addition, participating hospitals are responsible for offering appropriate and acceptable transportation between the designated hotel and the hospital within the governorate if it's required. The survey team leader, in collaboration with GAHAR survey coordinator, will determine the meeting point and pick-up time at the hotel. It is the responsibility of the team leader to maintain effective communication with all team members to ensure full compliance with the survey schedule and agenda.

Survey Team Structure and Responsibilities

On-site hospital accreditation surveys are typically conducted by a team of two to four surveyors, depending on the size, scope, and complexity of the hospital. The number of surveyors is determined by GAHAR, and the team is typically composed of teams with expertise in different areas of healthcare, such as infection control, medication management, and other relevant fields.

The survey follows actual patient care through the facility and includes reviewing documentation, interviewing staff, observing the hospital's administrative and clinical activities, and assessing the physical facilities and medical equipment.

The team leader: is the one who is responsible for assigning each team member to specific chapters and, where appropriate, individual standards within their area of expertise. Key responsibilities of the team leader include:

- Coordinating the overall survey process
- Managing the survey agenda and on-site activities, including document reviews and daily briefings
- Compiling survey findings and ensuring team consensus on scoring
- Preparing and submitting the final survey report and rating scores to GAHAR

- Identifying areas for improvement that the healthcare organization can consider enhancing performance in accordance with GAHAR standards

Survey coordinator responsibilities (hospital):

- Person responsible for managing the hospital's survey schedule and directing the hospital's survey agenda during the survey (document review session, briefing session, orientation to the hospital services).
- Facilitate efficient movement between hospital locations throughout the day.
- Arrangements for the survey.

The Survey Activities

During the survey visit, surveyors are required to review standards requirements and assess each standard through evidence of compliance (EOC) assessment to ensure the actual compliance with standards and are used as the basis for scoring.

Evidence of compliance with a standard indicates what is reviewed and assigned a score during the on-site survey process.

The EOCs for each standard identify the requirements for full compliance with the standard, as scoring is done in relation to meeting EOCs.

The surveyor assesses the compliance with the standard's requirements across the hospital by collecting data through four main methods, including the following:

Assessing compliance is accomplished through four main methods, including the following:

1. Interview the staff and patients to receive information concerning the implementation of standards.
2. On-site observation
3. Review of documents that demonstrate compliance and assistance in orienting the surveyor(s) to the hospital's scope and operations.
4. Tracing a sample of active patients through their experiences of care in the hospital and the systems of care.

N.B. The number of patient tracers for each surveyor depends on the size and the scope of the facility and is determined by the team leader and the survey team members prior to the survey visit.

Types of GAHAR Surveys

The Accreditation Onsite Survey is a scheduled, on-site review of all services and systems in a healthcare facility, conducted by GAHAR surveyors to assess compliance with GAHAR accreditation standards and identify systemic strengths or weaknesses. It includes staff interviews, direct care observations, document and policy review, and data validation.

Focus (Targeted) Survey is a narrow-scope, targeted onsite review concentrating on specific areas of concern. Usually triggered by previous GAHAR report deficiencies and focuses on partially met scored standards, not met scored standards, and not applicable standards if they become applicable. The aim is to ensure that identified issues have been corrected and sustained over time.

Resources for effective GAHAR survey preparation
GAHAR provides hospitals with the following resources to support their preparation for surveys:

1. Hospitals Provisional Accreditation standards.
2. GAHAR Handbook for Hospital Accreditation Standards
3. GAHAR Accreditation Guide
4. Self-Assessment Tool (SAT)
5. Inquiries about standards of interpretation and implementation

GAHAR responds to requests for interpretation of accreditation standards. The hospital can send a request through submitting and filling the inquiry form found on GAHAR official website through the following steps. Visit gahar.gov.eg, core functions, under the core function, under the icon of standard research and development, then select “inquiries of standards interpretation and implementation”. OR send an email directly to

standards-institute@gahar.gov.eg , SDR@gahar.gov.eg.

B. During On-Site Survey Processes:

GAHAR Tracer Methodology for Hospital Accreditation Surveys

Tracer Methodology

Tracer methodology is a dynamic evaluation approach used by surveyors to evaluate the actual implementation of healthcare standards within real clinical and non-clinical processes. It enables surveyors to follow the care experience of a patient, system, procedure, or process in real-time to determine whether the facility's operations align with defined quality and safety practices. During a tracer, surveyors do not evaluate individual staff performance. Instead, they observe the care process and operational processes to assess how effectively the organization aligns with the established GAHAR standards.

Types of Tracers:

A) Patient Journey Tracer

An individual tracer follows the care process of a real patient to assess compliance at each point throughout their care journey. It involves reviewing the patient's medical record, interviewing the staff involved in their care, observing care settings, and, when appropriate, interviewing the patient or their family to gain understanding of the care delivered.

Follow the patient care timeline step-by-step, but prioritize high-risk or critical points (e.g., surgery, blood transfusion, ICU care).

Example: A patient admitted through the emergency department with chest pain is followed through their journey from ER assessment, ECG, lab testing, cardiology consult, ICU admission, and finally discharge. The tracer assesses whether appropriate care was provided at each step and if standards were followed (e.g., timely ECG, informed consent, medication safety, hand hygiene).

B) System Tracer

A system tracer assesses a specific hospital-wide process or system from start to finish, evaluating how it is implemented consistently and integrated across all relevant departments. It focuses on ensuring that policies, procedures, training, and quality improvement mechanisms are effectively in place and functioning throughout the organization. It emphasizes how systematic processes impact patient safety and care effectiveness.

GAHAR developed four types of system tracer:

- Environmental and Facility Safety
- Medication Management and Safety
- Infection Prevention and Control
- Information management and Technology

Example: A tracer on infection control follows how hand hygiene protocols are applied from the outpatient clinic to the ICU. It checks the availability of sanitizers, staff knowledge, training records, compliance audits, sterilization practices, isolation procedures, and infection incident reporting.

GAHAR priority areas in tracer activities:

Priority areas are defined as core areas of focus in care and service delivery that represent high-risk, high-volume, or problem-prone processes within the healthcare setting. These areas are selected for in-depth evaluation using the tracer methodology, which allows surveyors to observe the real-time implementation of GAHAR standards.

Each priority area integrates multiple standards, reflecting the interdisciplinary nature of patient care and hospital operations. Through tracing specific patients, procedures, or processes within these areas, surveyors assess the integration, consistency, and effectiveness of practices as they relate to GAHAR's quality and patient safety standards.

Before starting tracer activities, a surveyor(s) may apply one or both of the following steps, depending on the specific situation, survey scope, or available information from the facility to determine priority areas. These steps ensure a focused, effective, and risk-based evaluation. Here's what a surveyor should do:

- Check previous survey findings If it's a re-accreditation, note any past noncompliance or areas of concern.
- Review infection control, incident reports, and sentinel events (if available).
- Analyze performance indicators (e.g., falls, medication errors, HAIs, readmissions, infections, mortality), and patient feedback (e.g., complaints, survey results, and trends).
- Identify high-risk areas by focusing on departments or processes that are high-risk or high-volume (e.g., Emergency, ICU, OR), problem-prone, or critical to patient outcomes, such as medication management and infection control.
- Prioritize by focusing on areas with high potential patient harm, complex care pathways, transitions of care, interdepartmental coordination, and trends indicating non-compliance or con2cerns.

The following priority areas, but not limited to these, are commonly selected for tracers during GAHAR accreditation survey. Focus priority areas could include:

- Patient Safety
- Effective Communication
- Environmental and Equipment Safety
- Workforce Competency, Credentialing, and Staffing
- Medication Management and Patient Safety
- Infection Prevention and Control
- Patient Flow and Continuity
- Care Coordination and Transitions of Care (Referral, Handover, and Discharge)
- Multidisciplinary Care Planning
- Timeliness and Accuracy of Diagnostic Results
- Ethical Management and Staff Engagement
- Information Management, Confidentiality, and Security
- Patient Rights

Guiding Principles During Survey Activities

Surveyor code of conduct:

- Focus on evidence-based observation, not assumptions or opinions, by verifying compliance with GAHAR standards through actual documentation, staff interviews, and real-time practices.
- Use open-ended questions to explore staff understanding and real-life application of policies and procedures.
- Never disclose or discuss patient details in public or open areas.
- Always handle all patient records and documents discreetly and professionally.
- Patient privacy and confidentiality must be upheld at all times during tracer activities and sessions. Surveyors and hospital staff should ensure that the integrity of patient care is maintained and that survey activities do not disrupt the provision of clinical services.
- Surveyors will follow the survey activities as scheduled in the agenda, maintaining open and ongoing communication with hospital staff.
- Avoid interrupting patient care during the survey process. The hospital should limit the number of staff members accompanying the tracer to a small group appropriate to the type of tracer being conducted.
- Show respect to staff and patients

- Avoid giving advice.
- Cooperation and coordination with the survey team.

Hospital guiding principles:

- For each tracer, include only hospital staff directly involved in the patient's care or the system being evaluated (e.g., doctors, nurses, and pharmacists for patient care tracers), and ensure they are fully available and committed throughout the tracer process.
- Avoiding overcrowding in patient care areas; only essential personnel should follow the tracer process.
- Do not interrupt active patient care or emergency procedures. Patient safety must always be the top priority.
- Unassigned or extra staff should not join tracer activities to avoid distractions and ensure the patient's comfort and privacy.
- Consultants and individuals not working in the facility should not attend the survey process.

Onsite Survey Activities – Explanation

1). Arrival and coordination session

Aim

The surveyors arrive at the hospital on schedule to start the survey activities meet the survey agenda.

Location:

The surveyors will meet in a room that has been designated as a meeting space by the hospital.

Who should collaborate?

GAHAR surveyors and representatives from the hospital staff and leaders.

Preparation requirements

- The hospital identifies a specific location where surveyors can wait comfortably for the organization staff to arrive. In addition, a dedicated space must be designated to serve as the surveyors' central base throughout the survey, allowing them to return between conducting surveys.
- The designated area should be equipped with a desk or table, reliable internet and phone connectivity, and access to an electrical outlet, if available. The hospital shall also provide the contact details of the survey coordinators, including their names and phone numbers.

2). Opening Conference and Agenda Review

Aim

The purpose of the Opening Conference is to initiate the accreditation survey and establish a shared understanding between the survey team and hospital leadership. This session introduces key participants, reviews the survey objectives and agenda, clarifies roles and responsibilities, and promotes transparency and collaboration throughout the survey process.

Who should collaborate?

GAHAR Surveyors

And From the Hospital

- Hospital leaders: Hospital Director, Medical Director, Nursing Director, Administrative Director, Operations Director
- Quality Manager
- Academic and Research Director (if applicable)
- Survey Coordinator
- Department leaders representing key clinical and administrative departments
- Other staff, such as trainees, students, and others, at the hospital's discretion

Location:

A designated room or space large enough to accommodate all participants and allow for interactive discussion.

Preparation requirements

- Organize a meeting space or conference room that adequately accommodates the surveyors, leaders, key hospital executives, and survey coordinator.
- The room should be large enough to accommodate all participants comfortably, with enough space for tables, chairs, and any presentation materials that may be used.
- The room should be in a central location and easily accessible to all participants.
- The room should be equipped with a projector and screen, as well as a whiteboard to spread out their work so that surveyors can share their work and collaborate.
- The surveyor(s) will wear an identification card that clearly identifies them as GAHAR surveyors(s).

The hospital will assign a survey coordinator to facilitate efficient movement between hospital locations throughout the day.

Documents required for review

Hospital survey agenda

Opening session activities

- GAHAR surveyors and the hospital director or representative will be introduced to each other, including their roles and areas of expertise.
- The surveyors will review the survey agenda with hospital leaders and adjust as needed. They will also be available to answer any questions regarding the agenda, ensuring that everyone clearly understands the scope of the survey.
- The team leader will explain the survey process and timeline, including document reviews, interviews with staff and leaders, facility tours and observations, and will discuss any necessary adjustments to the agenda to accommodate the hospital's workflow.
- The team leader will highlight the importance of following the guiding principles during tracer activities, including the surveyor code of conduct and the tracer methodology guiding documents.
- The surveyors will then answer any questions that the hospital leaders may have about the survey process.
- Hospital leaders and staff are encouraged to ask questions and seek clarification from the surveyors at any time throughout the survey process.

The Surveyors Team Leader explains the ground rules at the beginning of the visit, which include the following:

- All staff should be prepared to answer questions clearly and accurately when approached by surveyors. Staff should only respond when specifically asked.
- Relevant supporting documents required for review should be readily available during the survey sessions.
- A designated point of contact should be available throughout the visit to coordinate logistics, assist surveyors, and address any emerging needs.

3). Orientation to the Hospital's Services

Aim

The hospital provides the surveyors with a comprehensive overview of its mission, scope of services, strategic activities, and programs. This includes any additional services, such as high-risk services, that may require focused evaluation during the survey.

The presentation should also include details about the hospital layout, key departments, patient population, outpatient and emergency visits, annual admissions, surgeries, major interventions, and human resources. If available, information on the hospital's medical education and research programs should also be included.

The session is intended to give the surveyor(s) an introduction to the hospital through a presentation.

Location:

Meeting room that has been designated by the hospital as the same place in the Opening Conference and Agenda Review.

Who should collaborate?

GAHAR Surveyors

And From the Hospital

- Hospital Director
- Medical Director.
- Nursing Director.
- Survey coordinator
- Quality director/coordinator
- Department Heads (as relevant to services discussed).
- Academic and Research Director (if applicable).

Preparation requirements

GAHAR survey team leader will review the hospital's submitted application and prior accreditation reports.

Prepare a comprehensive, concise 10-slide maximum presentation that highlights key information about the hospital.

Documents required for review:

The following supporting documents shall be reviewed during this session:

- Organizational structure chart
- Strategic and operational plans
- Annual service volume reports (admissions, surgeries, outpatient visits).
- Licenses and certifications for specialized services (e.g., transplant, ICU).

Activities:

At the beginning of this session, a brief 15-minute presentation should be provided to the surveyors, presenting relevant information about the hospital.

The hospital director or representative should prepare a concise presentation covering the following topics:

- Brief description of the hospital's mission, vision, and strategic goals.
- Overview of the hospital's organizational structure, including its departments, units, and locations.
- Scope of Services: Bed capacity, annual patient volume, key departments.
- Patient Population: Demographics, common diagnoses/procedures.
- Special Programs: Academic, research, or high-risk services (if applicable).
- Compliance Highlights: Pre-accreditation improvements, safety initiatives.
- Ensure supporting documents (e.g., organizational charts, annual reports) are on hand.

4). Document review session

Aim

The document review session is for the surveyors to review the hospital's policies, procedures, and other documents to ensure that the hospital has the required policies and procedures in place, evaluate its compliance with GAHAR accreditation standards, identify areas for improvement, and collect information for upcoming survey activities, such as a tracer tour.

This session also helps GAHAR surveyors understand hospital operations and assess standards that require written evidence of compliance.

Location:

Designated meeting room(s) or the survey team’s workspace within the hospital premises, where all relevant documents can be accessed and reviewed efficiently.

Who should collaborate?

GAHAR Surveyors

And From the Hospital

Staff members who are directly involved with or responsible for the documents under review should be available during the survey process, as surveyors may need to discuss specific details with them to clarify information and gather further insights.

Document preparation:

The document review session is carried out by the surveyors only, but relevant staff should remain nearby and be accessible to address any questions or provide additional information if requested.

Before the session, the hospital should:

- Identify and assign staff members who are familiar with the relevant documents to be available for discussion (e.g., quality, HR, clinical).
- Organize all necessary documents in an accessible location (physical or digital).
- Group documents by GAHAR standards within each chapter, organizing evidence of compliance (EOCs) for each standard into subcategories such as policies, programs, procedures, reports, etc.
- Provide a clear, numbered index or table of contents for each chapter that lists the EOCs for each standard, with references to each document and its location (physical folder or electronic folder) separately.

- Ensure the documents are up to date, approved, complete, and clearly labeled or classified for easy and quick navigation.
- The hospital should limit attendance to selected staff as deemed appropriate.
- Use secure digital storage with access permissions; maintain backup copies to avoid data loss.
- For digital documents the hospital shall assign a coordinator to manage and facilitate access to all digital documents during the review session.
- Ensure all digital documents have clear version numbers and approval dates, with only the latest approved versions accessible to surveyors.
- Protect sensitive data with multi-factor authentication and encryption.
- Maintain regular automated backups and verify their integrity for quick recovery if needed.
- Index documents with searchable keywords and provide navigation aids such as bookmarks for easy retrieval.
- Provide surveyors with access only to relevant documents through unique usernames and carefully assigned user roles to prevent unauthorized use or changes.
- Have a printer available for paper copies when extensive review or scanning is necessary.
- Have staff prepared to explain how documentation is applied in practice and to answer any related questions.

Documents required for review:

The following documents shall be reviewed during this session:
(Which should include, but is not limited to, the following)

- Quality Management System Documents:
  - Policies and procedures related to clinical care, education, and research.
- Licenses and certifications
- Human resources policies and procedures
- Clinical guidelines, protocols, and care pathways, including emergency management protocols.
- All hospital-required plans and programs (e.g., quality improvement plans, risk management programs, infection control plans, etc.)
- Training and Competency Records:
  - Staff training records
  - Competency assessments
  - Continuing education logs

- Performance Monitoring and Improvement data from the previous year:
- Patient Care Records:
  - Patient flow tracking records documenting the movement of patients through different hospital departments or care stages
  - Approved symbols/abbreviations list.
  - The list of not-to-use symbols/abbreviations
- Environmental, Facility Management, and Safety Documents
- Annual risk assessments
- Infection surveillance data from the previous year

Activities:

During the Document Review Session, GAHAR surveyors review the hospital's key documents and records to assess compliance with GAHAR standards, checking for accuracy, completeness, and consistency. The hospital survey coordinator plays a vital role in facilitating this process by ensuring all necessary documents are organized, complete, and readily accessible.

The coordinator acts as the primary contact, helping surveyors locate specific files and promptly providing any additional information requested.

Following the Document Review Session, surveyors may identify areas that require additional clarification or further evidence. The hospital coordinator facilitates the scheduling and organization of these meetings to maintain effective communication and support the ongoing survey process.

Supporting Standards:

All standard chapters will be discussed in this session.

5). Daily briefing

Aim

GAHAR surveyor will provide a summary of the previous day's findings to explain how the survey process works, clarify any observations, and align on the agenda and expectations for the current day.

Location:

Meeting room that has been designated by the hospital as the same place in the Opening Conference and Agenda Review.

Who should collaborate?

GAHAR Surveyors

And From the hospital:

Key hospital leaders and representatives as determined by the hospital, based on relevance to the previous day's survey activities. This typically includes (but is not limited to):

- Hospital Director
- Quality Manager
- Survey Coordinator
- Heads of departments or units visited the previous day
- Other staff members relevant to the findings (e.g., Nursing Director, Medical Director, Infection Control director/officer).

Location:

A room should be available to accommodate all attendees. If there are several surveyors, the briefing will be conducted individually with each surveyor, facilitated by the survey team leader.

Activities

- Begin the session by greeting hospital participants and highlighting the positive points observed during the survey.
- GAHAR surveyors will provide a concise summary reflecting on the previous day's activities and key observations.
- The session will provide an overview of key findings from the previous day while emphasizing important positive results, without reviewing all compliant areas.

- Highlight major or recurring non-compliance issues or trends of concern.
- The hospital team will be given the opportunity to respond to observations, provide supporting documentation, and clarify any points needing further explanation.
- Inform the hospital that final findings for any given standard will be determined only after all survey activities are complete and results are fully aggregated.
- Surveyors and hospital staff should maintain open, transparent, and respectful communication throughout the process.
- Hospital representatives may take notes on items requiring clarification or later submission.
- This session facilitates ongoing communication, allowing the hospital to clarify potential non-compliance findings or address any identified deficiencies in a timely manner.

6). Leadership and Financial Stewardship Interview

Aim

The purpose of the Leadership Interview session is to find out how hospitals are governed, managed, and structured, as well as how leadership coordinates, measures, evaluates and improves the quality and safety of care over time.

This session also explores the strategic planning process and how it is selected, developed, communicated, and evaluated. It identifies the organization's strategic priorities and core values. Additionally, it evaluates the implementation of an ethical framework and discusses how leadership has developed a culture of safety within the hospital. The session also examines the hospital's financial management activities.

Location:

Meeting room that has been designated by the hospital.

Who should collaborate?

GAHAR Surveyors:

And From Hospital:

- Governing body representative, if applicable
- Hospital Director
- Medical responsible leader/hospital leaders
- Human resources management leader
- Purchasing / Financial Manager
- Quality Manager / Coordinator
- Performance improvement coordinator.
- Supply chain representative
- Responsible leader or representative of academic and medical education research (academic medical center hospitals only).

Preparation requirements:

Documents required for review:

The following supporting documents shall be reviewed during this session:

- Hospital organizational structure.
- Hospital strategic plan.
- Hospital operational plan.

- Terms of Reference of hospital committees.
- Governing Body minutes, at least 6 months related to the quality reports.
- Ethical management practices and code of conduct or ethics.
- Outcome and process measures of the staff health program.
- Evaluation of the culture of patient safety.
- List of hospital initiatives (complaints/feedback/improvement initiatives)
- Billing process policy and related data, including major purchasing decisions and financial audit schedules.
- Utilization management projects
- Staff healthy working environment measures
- Community health needs assessment
- Occupational health/safety programs (Law No. 211/2020).

Activities

GAHAR surveyors may conduct discussions to evaluate leadership's involvement in quality, safety, risk management, ethics, research, and hospital-wide communication.

GAHAR surveyors may address the following discussion topics.

- Organizational structure, composition of the governing body, and inclusion of different managerial roles and responsibilities.
- Discussion about the effective modes of communication in the organization that ensure patient safety and achievement of clinical targets including operational meetings, committees' structure, direct or electronic communication.
- Discussing how the strategic plan aligns across the hospital, including how it relates to the operational plan.
- Leadership commitment to ensuring compliance with regulatory bodies including laws and regulations.
- Description of the relationship between the governing body and the facility surveyed, including accountabilities, bylaws, and reports.
- Discussing how leadership evaluates and improves the quality of care and safety, creating a culture of safety provided to patients.
- Action plans for patient safety and ethical improvements.
- Discussion may include the quality and patient safety program, including priorities of improvements, sentinel events, adverse events, and near misses, including corrective and preventive action plans.
- Information about how leadership develops a culture of safety and continuous

improvement among staff members.

- Discussing the hospital's establishment and implementation of ethical values, codes and, policies / Research ethical practices within the organization.
- Reviewing financial practices, budgeting, and cost-control measures.
- Discussion about contracted services selection and evaluation including discussion of the performance indicators to ensure patient safety.
- Staff Health program components, evaluation, and outcomes.
- The surveyors discussing information about the community assessment program.

The surveyors will likely engage hospital leadership and other participants in discussions, review documentation and policies, and conduct interviews.

Supporting Standards

Standards from the following chapters:

- GAHAR Safety Requirements (GSR)
- Organization Governance and Management (OGM) chapter
- Patient-Centeredness Culture (PCC) chapter
- Academic and Teaching Hospitals (ADD) chapter
- Quality Performance Improvement (QPI) chapter
- Other related standards, as applicable

7). Quality Management and Patient Safety Session

Aim

To help to identify the leader's role in supporting quality, patient safety, and risk management programs. Additionally, they facilitate the assessment of current practice strategies support quality, provide insight into existing challenges, and help to understand challenges and identify existing quality improvement measures and evaluate their effectiveness.

Leaders and quality teams can provide firsthand insights into ongoing improvements, staff training, and how program goals align with the organization's overall strategy.

A presentation format is recommended for this session to present quality and safety improvement program activities and clinical and managerial indicators, as well as key improvement projects.

Location:

Room that has been designated as a meeting space by the hospital.

Who should collaborate?

GAHAR Surveyors
And From Hospital

- Hospital leaders: Hospital Director, Medical Director, Nursing Director, Administrative Director, Operations Director
- Quality Manager, or coordinator
- Members of the Quality Team and Quality Committee
- Quality Champions and staff involved in Quality Improvement (QI) projects and performance measurement initiatives
- Risk Manager and members of the Risk Management Team

Preparation requirements:

GAHAR surveyors may need a quiet area for brief interactive discussion with staff who oversee. The quality management program. Then they will trace the different quality measures (managerial and clinical) and the implemented improvement projects in their relevant sessions.

Documents required for review:
The following supporting documents shall be reviewed during this session:

- Quality and patient safety program / Risk management program
- Terms of Reference of hospital quality improvement committees

- Minutes of quality improvement committees, task forces
- Evaluation of committee's performance for reaccreditation surveys
- List of improvement initiatives
- List of measures, outcome, analysis, and actions.
- Example of data validation
- Example of benchmark
- List of root cause analyses (RCAs) with related action plans
- Proactive risk assessment
- Staff training records.
- Incident reporting system and data trend analysis

Activities

In this interactive session, the surveyor(s) will discuss processes related to quality, patient safety, and risk management, covering relevant practices, challenges, and improvement initiatives, for example:

- Description of the relationship between the organization leaders and quality improvement team.
- Method of communication between the quality team and the hospital department.
- Discussion of examples of challenges reviewed by the Quality Improvement Committee and the decisions made.
- Methodology used by the Quality Team to support departmental performance.
- Type of measures, sampling methodology, reporting, and setting targets.
- Hospital improvement projects.
- Discuss data management program, tools, reporting, and communication.
- How the organization selected the measures, project, and follow-up the progress.
- Process of conducting root cause analysis, selecting the team, and documentation.
- Check the hospital incident reporting, management system, and review system activities in the hospital, including identification, analysis, and corrective and preventive action process
- Discuss the proactive risk analysis, the selected tool, leaders support, and follow up the risk level.
- Discuss quality team training and staff training.

Further discussions may be conducted following the Quality and Performance Improvement interview session to explore additional details or respond to hospital-specific concerns.

Supporting Standards

- Quality Performance Improvement (QPI) Chapter
- Standards related to governance, including effective communication with the governing body, oversight by the governing body, and review of quality reports under the Organization Governance and Management (OGM) Chapter.

8). Patient journey tracer

Aim

The purpose is to provide a clear understanding of how patient care is tracked and integrated across various disciplines and services within the healthcare system, with a focus on ensuring continuity of care across departments and throughout the different care delivery phases, including outpatient, inpatient, discharge, and follow-up. By following the patient's journey, this session will help surveyors assess the effectiveness of clinical and non-clinical processes. This process also highlights areas for improvement and encourages a continuous focus on patient safety and quality care delivery.

Who should collaborate?

GAHAR Surveyors (One surveyor or two),

From hospital:
The hospital should involve a multidisciplinary team that directly participates in the patient's journey tracer. The following hospital staff should attend:

- individuals directly involved with the specific patient traced
- Primary physicians and specialists involved in the patient's diagnosis and treatment
- Nurses who provide direct patient care
- Pharmacists overseeing medication management
- Laboratory and imaging staff if relevant to the patient's diagnostic or treatment process
- Allied health professionals (e.g., physiotherapists, dietitians) if involved
- Quality and patient safety coordinators
- When applicable, housekeeping or other support staff if their role impacts patient care at certain points (e.g., infection control)

Preparation requirements:

Document required for review:

The following documents shall be reviewed during this session:
The medical records of patients actively receiving care in the department or setting shall be reviewed during this session.

Patient Tracer Selection Criteria/Patients Likely to Be Selected for Tracer Activities
Patients selected for the tracer should meet the following criteria:

- Based on the scope of the healthcare facility, a patient is selected from the patient list.
- Patients who transition across different care departments or programs, such as between inpatient hospital services and outpatient clinics.

- Patient is either currently admitted or recently discharged, to reflect current practices.
- Patients receiving multiple services and interventions from various departments or specialties, often seen in patients with comorbidities, such as heart surgery with diabetes and hypertension; stroke with atrial fibrillation and pneumonia with chronic kidney disease; or cancer with anemia and infection.
- Patients receive special service in the hospital as if they were in a prison or refugees, or a specific program.

GAHAR surveyors may require patient tracers per survey day, based on the size and scope of the facility. The number and selection are determined by the team leader and designated survey team members prior to the survey, ensuring a thorough evaluation of standards implementation.

Activities

The tracer survey begins at the patient's location with the patient's open medical record. The surveyors(s), with assistance from the staff responsible for the patient, will select patients from the active patient list.

Using the medical record, the surveyor will map the patient's journey from admission to discharge or current status. While the entire medical record is reviewed, the primary focus will be on clinical areas relevant to the patient's condition (e.g., operating room, inpatient units) and how these integrate into the overall care process within the organization.

During the tracer activity, the following steps will be undertaken as appropriate:

- Review the medical record, which forms the basis for subsequent activities and interviews. Additional questions may be prepared to clarify unclear points or integration issues.
- Interview relevant staff involved in the patient's care, such as nurses, physicians, dietitians, clinical pharmacists, etc.
- Interview the patient and/or their relatives.
- Review other records as needed to validate any concerns or unclear topics.
- Observe the patient care process.
- Evaluate compliance with standards during observations and interviews, providing immediate feedback for any critical safety issues.

The tracing activity is usually guided by priority areas, determined beforehand or identified during the record review. Relevant documents, such as protocols and handover records, will also be reviewed as part of the process.

Supporting standards:

All standard chapters are covered in this session.

9). Environmental and Facility Safety Document review session

Aim

The aim of this session is to conduct a document review and engage in discussions to evaluate key components related to facility management and safety, including leadership commitment and the roles and responsibilities of leadership in managing safety programs. The session objectives are to assess the hospital's compliance with GAHAR Environmental and Facility Safety standards, identify strengths and areas for improvement in facility management and safety programs, provide actionable recommendations to enhance safety and risk mitigation, and support continuous improvement through the integration of safety practices into daily operations.

Location

GAHAR surveyor may need a quiet area for interactive discussion with hospital participants and document review.

The location should comfortably accommodate the surveyor, hospital participants, and required materials and be equipped with necessary technology for presentations and document sharing.

Who should collaborate?

GAHAR Surveyors (Assigned Surveyors(s)

From the hospital

- Supervisory Engineers (Electrical, HVAC, Biomedical, Civil)
- Environmental and Facility officer/staff
- Safety Officer / Environmental Health and Safety Representative
- Environmental and Facility Manager
- Fire Safety Officer
- Infection Control Officer / Representative
- Quality Manager or Coordinator
- Survey Coordinator

Preparation requirements:

Document required for review:

The following supporting documents shall be reviewed during this session:

1. **Plans, Policies, and Procedures:**
   - Risk assessment and monitoring
   - Safety rounds and inspections
   - Security management
   - Hazardous materials and waste management
   - Fire safety (including fire safety plans, layouts, and evidence of drills)
   - Medical equipment management (inventory, preventive maintenance schedules, and selected equipment files)
   - Utility systems (inventory, preventive maintenance schedules, and selected equipment files)
   - Emergency and disaster management (drills, assessments, and response plans)
   - Construction and renovation activities (Pre-Construction Risk Assessment [PCRA] and Infection Control Risk Assessment [ICRA])
2. **Inspection Reports:**
   - Current and accurate inspection reports of the hospital's physical facilities
   - External audit reports (if applicable)
3. **Safety Committee Documents:**
   - Terms of reference for the Safety Committee
   - Committee membership list
   - Approved meeting agendas and minutes
   - Attendance sheets
   - Facility safety tour reports
   - Corrective and preventive action plans
   - Budgeting for long-term upgrades and replacements
   - Occurrence Variance Reports (OVRs) related to facility safety, with action plans to prevent reoccurrences
4. **Specific Program Documents:**
   - Clinical Laboratory Safety:
     - Laboratory safety program
     - Laboratory safety policies and procedures
     - Equipment maintenance and safety records

- Radiology/Diagnostic Imaging Safety:
  - Radiology safety program (including safe use of lasers, electrosurgical, and other optical radiation devices)
  - Radiology safety policies and procedures
  - Equipment maintenance and safety records
- Emergency and Disaster Management:
  - Emergency response plans
  - Documentation of drills and critiques
  - Community and regional emergency management coordination plans.

5. **Biannual Report:**
   - A biannual report submitted to the hospital's governing body regarding significant observations during environmental and facility surveillance rounds, with corrective actions taken or needed.
6. **Staff Training Plans and Records:**
   - Staff training plans and records for the environment and facility safety program.

Activities:

Interactive session:

This session will be conducted as follows:

Surveyors introduce themselves and explain the purpose and scope of the session. The hospital provides a brief overview of its facility safety programs and key personnel involved. Hospital participants may ask questions or provide additional clarifications on facility safety programs. Surveyors will address any concerns or gaps identified during the session.

GAHAR surveyors will discuss with hospital participants to discuss the main pillars of the environmental and facility safety chapter. They will address the following topics:

- Development, implementation, and evaluation of facility safety programs.
- Risk assessment processes and how risks are monitored and mitigated.
- Improvements achieved and lessons learned from past incidents or audits.
- Specific focus areas:
  - Emergency and disaster management (e.g., community role, information sharing, incident response structure).
  - Fire safety and hazardous materials management.
  - Medical equipment and utility systems safety.
  - Construction and renovation of safety measures.

GAHAR surveyors will reference observations from the facility tour and discuss the alignment between documented policies and actual practices as well as any areas of concern or non-compliance identified during the tour.

Surveyors will summarize key findings, including strengths and areas for improvement. Hospital participants will provide information on existing activities or plans to address identified concerns.

Supporting Standards:

- Environmental and Facility Safety (EFS) chapter: This is the primary chapter for this session.
- Workforce Management (WFM) chapter: Includes the Orientation Program and Continuous Education Program.
- Quality Performance Improvement (QPI) chapter: Covers performance and clinical measures, data aggregation, analysis, and validation, as well as the Risk Management Program.
- Infection Prevention and Control (IPC) chapter: include IPC program, risk assessment, environmental cleaning, transmission-based precautions, and planning for construction or renovation.

10). Environmental and Facility Safety Tracer

Aim

The purpose of the Environmental and Facility Safety Tracer is to evaluate how effectively the hospital ensures a safe, functional, and supportive environment in alignment with GAHAR standards. The tracer involves direct observation, staff interviews, and review of processes and documentation to assess the implementation of safety systems, infrastructure conditions, risk management, and emergency preparedness. It also aims to evaluate staff knowledge of relevant standards, verify effective implementation across all areas, and ensure compliance through examining additional documents in key departments (e.g., pharmacy, laboratory, infection control, and facility safety).

Location:

Surveyors will visit at least the following areas:

- Laboratory Department
- Radiology Department
- Inpatient Areas:
  - Patient Care Rooms
  - Bathrooms
  - Nurse Stations
  - Unit Stores
  - Clean & Dirty Utility Rooms
  - Operating and Procedure Rooms
  - Dental Clinics
  - Dermatology Clinics
  - Laser OPD/OR
- Non-Clinical and Operational Areas
  - Rooftops
  - Generator room and electrical room
  - Medical gases room
  - Maintenance workshops
  - Main store
  - Reverse osmosis plant (if applicable)
  - Waste collection rooms

- Staircases and corridors
- Main entrances and emergency exit
- Isolation rooms
- Ambulances
- Kitchen, laundry
- Central sterilization

Who should collaborate?

GAHAR Surveyors (Assigned surveyors (s)

From the hospital
The following hospital representatives could attend the Environmental and Facility Safety Tour and Unit Visits:

- Environmental and Facility manager or Engineer
- Infection Control Officer/Practitioner
- Quality Management Representative
- Safety Officer / Environmental Health and Safety Representative
- Nursing Director or assigned Head Nurses for Visited Units
- Housekeeping / Environmental Services Supervisor
- Biomedical Engineer (if applicable)
- Radiology and Laboratory Department Heads (when those areas are visited)
- Pharmacy Director or Representative (if pharmacy is visited)
- Security and Fire Safety Officer (if emergency preparedness is assessed)
- Relevant Department Leaders

Preparation requirements:

Assign a survey coordinator or guide to each surveyor to accompany them throughout the tour.

Document required for review:

The following supporting Documents shall be reviewed during this session:
Ensure the following documents are readily available for review during the tour:

- Fire safety inspection reports by area, including facility layouts and evidence of fire drills.
- Risk assessment and mitigation tools, such as:
  - Safety Data Sheets (SDS) for hazardous materials.
  - Medical equipment inspection cards and/or operation instructions (if applicable).

  - Preventive maintenance reports for utility systems.
- Laboratory safety program documentation.
- Medical equipment and lab supply inventories.
- Hazardous materials handling procedures and records.
- Radiology safety program documentation.
- Medical equipment inspection and maintenance records.
- Hazardous materials handling procedures and records.

Tracing activities:

During the Environmental and Facility Safety Tour, surveyors will conduct unit walkthroughs across selected clinical and non-clinical areas of the hospital. They will engage in direct observations, staff interviews, and review of documentation to assess how effectively safety and facility standards are implemented and maintained. The team will trace the environment from entry points to patient care areas and support services, evaluating safety systems in real-time operations.

- The overall facility condition assessment by the safety team.
- Fire and Life Safety:
  - Fire alarm systems, extinguishers, emergency exits, evacuation plans, and drills.
  - Staff knowledge of fire response procedures.
  - Hospital's firefighting system, from the source to control panels.
  - Ask staff about their roles in case of fire and the location of the nearest assembly point.
  - Review fire safety plans and evidence of fire drills onsite.
- Risk Assessment and Incident Response:
  - Ask staff to describe or demonstrate their roles in assessing risks and responding to incidents (e.g., equipment malfunctions, hazardous material spills).
  - Assess physical controls for minimizing risks (e.g., alarms, building features).
- Hazardous Materials and Waste Management:
  - Safe storage, labeling, and disposal of chemicals, sharps, and biomedical waste.
  - Availability and use of PPE by staff.
- Medical and Non-Medical Equipment Safety:
  - Proper use, maintenance, and calibration of biomedical equipment.
  - Safety checks and tagging of equipment.
  - Review the implementation of inspection, testing, and maintenance procedures for medical and non-medical equipment.

- Ask staff to demonstrate their role in responding to equipment malfunctions.

- Utility Systems:
  - Evaluate the hospital's emergency program for responding to utility system disruptions (e.g., power, water, medical gases).
  - Review repair services and engineering controls.
  - Assess systems for infection risk reduction during construction (assess PCRA, ICRA).

- Emergency Preparedness and Disaster Management
  - Assess the hospital's emergency and disaster management program, including mitigation, preparedness, response, and recovery strategies.
  - Review documentation of drills and post-drill evaluations.

Supporting Standards:

- Environmental and Facility Safety (EFS) is the primary chapter.
- Workforce Management (WFM) chapter: Includes the Orientation Program and Continuous Education Program.
- Quality Performance Improvement (QPI) chapter:
  - Incident reporting and analysis
  - Risk assessment and response to environmental hazards or safety issues
- Infection Prevention and Control (IPC) chapter:
  - Planning for construction or renovation
  - Covers environmental cleaning and hygiene
  - Risk-based planning during construction or renovation
  - Use of PPE and infection control in high-risk environmental settings

11). Medication Management and Safety Tracer

Aim

The session explores the efficient and effective medication management process across the hospital, identifying potential system risk points. It analyzes key processes, including medication selection, procurement, storage, ordering and transcription, preparation, and distribution, while assessing areas of strength and opportunities for improvement. Additionally, it addresses medication supply chain management, focusing on selection, monitoring, and evaluation.

The surveyor(s) will assess the hospital's real degree of compliance with relevant standards.

Location:

GAHAR surveyor may need a quiet area for brief interactive discussion with staff who oversee the medication management program.

During the tracer tour, the surveyor visits all areas of the hospital where a medication may exist for instance, pharmacies, crash carts, outpatient clinics, medication preparation areas, and medication storage areas in patient care units.

Who should collaborate?

GAHAR Surveyors (Assigned surveyor(s)

From the hospital:
Interview a staff member involved in medication management processes, at least the following staff members:

- Pharmacy director and pharmacy staff
- Chairman of the Drug and Therapeutics Committee.
- Medical staff, such as physicians or nurses who are involved in any phase in the medication managementprogram.
- Infection prevention and control representative
- Quality coordinator
- Supply chain representative.

During Tracer Tour:

GAHAR surveyors will interview hospital staff concerned with any process in medication management during the tour to assess the compliance.

Preparation requirements:

Document required for review:

The following documents shall be reviewed during this session:

- Medication management policies.
- Committee terms of reference & minutes
- Antimicrobial stewardship program data and reports documenting improvements.
- Drug Formulary and related data
- Emergency medication handling
- Approved list of high-alert medications, concentrated medications, and LASA (Look-Alike, Sound-Alike) multi-dose medications.
- Medication recall process
- Medication system, as CPOE, unit dose, etc.
- ADR reports, analysis, and action taken.
- Medication Errors Reporting file and action taken.
- MMS Indicators Report and data collection analysis.
- MMS Quality Improvement plans.
- Patients' educational materials.
- Medication supply chain management: selection, monitoring & evaluation

Activities

Part 1- Interactive session:

Starting with a session, which is a meeting with a selected group for discussion, the subprocess is as follows:

- Drug and Therapeutic Committee (DTC) minutes review.
- Pharmacy & Therapeutic role in medication selection and updating the medication lists or other lists of high alert and LASA.
- Role of the medical team with the pharmacy team in supporting the antimicrobial stewardship program.
- Patient and family education.
- Medication management data collection and improvement initiatives.
- Review data for medication errors, near-misses, and ADR and the surveyor may trace one of these events.

Part 2 - Tracer tour:

Medication tracing evaluates medication management and safety processes and systems and observes how medication management processes are implemented from the time a medication is selected for the hospital formulary, through procurement and storage, all the way to preparation, dispensing, administration, monitoring, and documentation.

The medication tracer follows the medication through all the steps of the medication management program. During the tracer tour, GAHAR surveyors will visit patient care areas and all areas in the hospital where a medication may exist and track the usage of a specific medication through a medical record, patient medication order, or high-risk list.

Surveyors focused on high risk medications, such as high alert medications, look-alike and sound-alike medications, narcotics, antibiotics, radiopharmaceuticals.

For example, a GAHAR surveyor may select a high-alert medication and begin tracing it from the point of patient admission through ordering, preparation, dispensing, storage, administration, and monitoring the medication's effects on the patient.

Supporting Standards

- The Medication Management and Safety (MMS) chapter is the primary chapter.
- Infection Prevention and Control chapter (IPC).
- Organization and Governance Management chapter (OGM)
- Information Management and Technology chapter (IMT)
- Integrated Care Delivery chapter (ICD)
- Critical and Special Care Services chapter (CSS)

12).Infection Prevention and Control Tracer

Aim

- To have an overview about the infection prevention and control program and to ensure it is implemented in the hospital as a multidisciplinary process.
- Ensures the hospital implements effective measures to prevent and control healthcare-associated infections, protecting patients, staff, visitors, and community.
- Verifies compliance with GAHAR standards and alignment with international evidence-based infection control practices.
- Assesses surveillance, risk assessment, risk mitigation plans, and outbreak management; evaluates the integration of IPC into quality improvement and staff training; and reviews resources, leadership support, and infrastructure to ensure safe care.

location

GAHAR surveyors may need a quiet area for a brief interactive discussion with staff responsible for the Infection Prevention and Control (IPC) program.

During the tracer tour, the surveyor visits various hospital areas where infection prevention and control practices are critical.

The following areas may be visited by surveyors:

1. Operating rooms
2. Central sterilization
3. Kitchen
4. Isolation rooms
5. Medical and surgical ICU, PICU,NICU
6. Hemodialysis unit
7. Endoscopy unit
8. Laboratory
9. Laundry
10. Dental clinic
11. Waste room
12. Mortuary
13. Protective environment (if present, e.g., bone marrow transplant unit)
14. Inpatient rooms

15. Emergency department
16. Sterile processing department
17. Hand hygiene stations
18. Waste disposal zones
19. Any high-risk patient care units
20. All supportive services (e.g., laundry, kitchen)
21. Any other areas that may be accessed or used by patients

Who should collaborate?

GAHAR Surveyors (Assigned surveyor(s)

From Hospital

The session should involve a multidisciplinary team. This group should include, but not be limited to, representatives from the following departments, as applicable:

- Infection prevention and control team (Officer/Practitioner, Head of the Infection Control Committee).
- Nursing Director or Nursing Supervisor
- Microbiologist or Laboratory Director
- Pharmacy Representative (for antibiotic stewardship and sterile prep)
- Housekeeping/Environmental Services Manager
- Facilities and Engineering Representative (for ventilation, water systems, etc.)
- Sterilization and sterile processing department staff
- Waste Management Officer
- Kitchen and Laundry Supervisors
- Representatives from hospital leadership

Preparation requirements:

GAHAR surveyor may need a quiet area for brief interactive discussion with hospital participants.

Documents required for review:
The following supporting documents shall be reviewed during this session:

Documents Review:

1. Infection prevention and control program.
2. IC risk assessment reports and related data
3. Terms of reference of the IPC committee.

4. Committee membership list and meeting minutes.
5. Committee annual report
6. Surveillance report
7. List of high-level disinfection and sterilization used.

Activities:

Part1 - Tracer tour

During the IPC tracer, the surveyor actively follows the path of infection prevention practices across both clinical and non-clinical areas of the hospital. They observe real-time procedures, inspect environments, review records, and interact with staff to verify that infection control measures are properly applied and effective.

The Infection Prevention and Control (IPC) tracer typically begins with a group meeting involving key hospital staff responsible for infection control. During the tracer process, the surveyor follows the patient care workflow or specific infection prevention activities across various hospital departments. This includes checking hand hygiene compliance, proper use of personal protective equipment (PPE), cleaning and disinfection procedures, and patient isolation protocols.

The physical environment is inspected for cleanliness, availability of IPC supplies, and proper waste management. Assess the proper infrastructure for the prevention of potential cross-contamination. Throughout the tracer, staff are interviewed to assess their knowledge of IPC protocols, antimicrobial resistance risks, and their roles in prevention efforts. Simultaneously, the surveyor reviews documentation, including infection surveillance data, outbreak investigation reports, antimicrobial usage and resistance patterns, staff training records, and IPC committee minutes.

Part 2 - Interactive session Discussion:

The interactive session began with a summary of key findings from the IPC tracer and a review of the hospital's IPC governance structure, including leadership oversight and committee function. The surveyor used IPC surveillance data to develop realistic scenarios, encouraging engagement from staff across departments. Key discussion areas included the infection risk assessment process, methodologies used, and how findings inform IPC strategies.

Focus was placed on identifying and managing high-risk patients such as those with fever of unknown origin, surgical site infections, or those in isolation due to infectious diseases or immunocompromised status. The surveyor also reviewed the use of Point-of-Care Risk Assessments (PCRA) or high-risk procedures and Infection Control Risk Assessments (ICRA), especially during construction and renovations.

The discussion explored the hospital's approach to detecting and managing infections, responding to global communicable diseases, and tracking antimicrobial resistance and

healthcare-associated infections (HAIs). Preventive activities such as staff training, patient and visitor education, environmental hygiene, and hand hygiene practices were reviewed, along with how surveillance data informs interventions and supports continuous monitoring and improvement. The management of contracted services was also reviewed.

Finally, participants explained the IPC reporting structure, frequency, KPIs tracked, and leadership accountability. The session reinforced the hospital's commitment to IPC standards and continuous improvement in patient safety.

Supporting Standards

- Infection Prevention and Control chapter (IPC) is the primary chapter.
- Environmental and Facility Safety chapter (EFS).
- Organization and Governance Management chapter (OGM).
- Medication Management and Safety chapter (MMS).

13). Information Management and Technology Tracer

Aim

To evaluate the effectiveness of the hospital's Information Management and Technology system by reviewing how medical records are initiated and managed, and also by assessing measures that ensure the confidentiality, security, and integrity of patient data. The session aims to verify staff awareness and training on data protection and access controls and to examine hospital policies on information security, including authorization protocols, breach response, and compliance with legal requirements for data retention and destruction. Surveyors will also assess medical record workflows, data backup processes, and downtime recovery plans to ensure continuous availability and protection of data in line with national and international standards. Additionally, the session will review procedures related to authorized access, archiving, retrieval, disposal, record standardization, auditing, IT system selection, and cybersecurity, covering telemedicine privacy where applicable.

location

A room designated by the hospital as a meeting space, providing a quiet area for surveyors to use throughout the survey.

Who should collaborate?

GAHAR Surveyor s(Assigned surveyor(s)

From Hospital

- Responsible staff from the Medical Records Department
- Information Management / Information Technology (IT) staff
- member of the Hospital Administration team
- A member of the Quality team, particularly if involved in auditing or related processes
- Other staff members are involved in medical records management, depending on the hospital's system

Preparation requirements:

- Hospitals should identify the participants involved in the Information Management and Technology Tracer.
- Participants should be selected from stakeholders engaged in relevant processes.
- All required supporting documents should be made available.

Document required for review:

The following documents shall be reviewed during this session:

- Information management structure and plan
- Policies on information management systems and security
- Orientation materials on the IMT system
- Audit logs of access to information and systems
- Contracts with third parties accessing organizational data
- Relevant laws and regulations on information management
- Performance measures
- Risk management plan related to information security

Activities

Part 1- Interactive session:

The surveyor will conduct an interactive session with a selected group to assess compliance with the standards. The session will include discussion on the following points:

- Discuss the information plan and information need assessment
- Identification and overview of the types of medical records used in the hospital (paper-based, electronic,
- Description of the hospital-wide information management system and measures in place to maintain confidentiality, security, and integrity of medical records in both paper and electronic formats.
- Clarification of who is authorized to access patient data and under what defined roles and conditions.
- The process of standardization and review of medical records across departments to ensure uniformity in completing medical records, including use of codes, symbols, and abbreviations
- The process of routine auditing and review process of medical records, focusing on accuracy, completeness, legibility, and timeliness.
- How the hospital identifies, documents, and organizes the different information needs across clinical and managerial services.
- The hospital follows a structured process to select, test, and evaluate information technology and EHR systems, ensuring they align with clinical and operational requirements.
- Procedures are established to identify and manage both planned and unplanned system downtimes to maintain continuity of patient care.

- Data backup system with defined storage, retrieval protocols, and regular testing ensures data integrity, availability, and effective disaster recovery.
- Telemedicine Services (if applicable): The hospital ensures privacy and cybersecurity of protected health information in telehealth services through data encryption, secure platforms, integrated systems for consistent patient data, and comprehensive staff training.

Part 2 - Tracer tour:

Based on the initial discussion, a site visit tracer can be planned to evaluate the medical record management system, starting from record initiation (patient registration or admission) and following the entire process through documentation, handling, archiving, and retention. The tracer will include an explanation of the archiving process, retrieval protocols, retention timeframes, and disposal procedures for medical records.

The tracer should verify how confidentiality, security, and integrity of patient data are maintained at each step, including physical security for paper records, access controls, authorization protocols, and compliance with retention and disposal policies.

Additionally, a separate tracer should assess the electronic medical record system, starting from end-user interfaces (clinical or nursing stations) toward the central data repository (hospital servers or cloud storage). This tracer will focus on system downtime protocols, data confidentiality and security measures (user authentication, role-based access, and encryption), and backup and retrieval procedures to ensure data preservation and prompt access in case of failures.

During the tracer, surveyors will interview a selected patient currently hospitalized, members of the IMT team to discuss patient information security topics (storage, access, electronic records, equipment management), and other healthcare personnel involved in the patient's care. Observations will be made on staff attitudes and compliance when handling medical records as well as the overall management of the organization's information system.

Both tracers and associated interviews and observations will provide a thorough assessment of paper-based and electronic record systems to ensure they meet quality, security, and operational standards.

Supporting Standards:

- Integrated Care D Information Management and Technology chapter (IMT) is the primary chapter.
- Integrated Care Delivery Chapter (ICD).
- Quality Performance Improvement chapter (QPI)

14). Patient Medical Record Review session

Aim

The purpose of the Closed Patient Medical Record Review is to confirm the hospital's compliance with GAHAR medical record documentation requirements during the look-back period. This review evaluates the consistency, completeness, accuracy, and timeliness of records; ensures alignment with GAHAR standards; assesses continuity of care and multidisciplinary documentation; and verifies that the recorded information accurately reflects the care actually delivered to patients.

Location:

A meeting room should be provided for the survey team throughout the survey, ensuring it is quiet, private, and secure with restricted access and immediate availability of computers for reviewing Electronic Medical Records (EMR). The room must be prepared in advance to comfortably accommodate the team, and it should be equipped with IT support to address any technical issues.

Who should collaborate

GAHAR Surveyors (All surveyors)

From Hospital

- Medical Records Officer / Information Management Specialist or Representative
- Quality Manager
- Survey Coordinator
- Medical director or Physician Representative who is aware of medical records
- Nursing Director or Representative who is aware of medical records
- Pharmacist (if medication use review is required)
- Infection Control Officer / Representative
- Relevant Department Heads (for specific specialty reviews)
- IT officer for any technical problems

Preparation requirements:

The hospital should assign staff members during the Closed Patient Medical Record Review who are familiar with both the medical records and clinical care processes. It is recommended to assign one staff member for each surveyor to assist by answering questions and explaining the documentation. Ensure the availability of a Closed Medical Record Review Form or other forms for documentation that comply with GAHAR standards.

Activities:

- GAHAR surveyors will randomly request at least 10 closed patient records per surveyor, selected to represent a cross-section of hospital services (e.g., surgery, emergency, internal medicine, Orthopedics). From the discharge over the last lookback period.
- The records may be selected based on specific diagnoses, procedures, or time frames, depending on the type of survey visit or findings from tracer activities.
- Surveyors may request additional file samples if initial reviews reveal concerns that need further verification.
- Each medical record will be briefly reviewed to establish the type of care provided and to determine if the documentation aligns with GAHAR standards, including verification of compliance over the required look-back period.
- Additional records may be requested if the initial review reveals concern that requires further verification.
- Surveyors may use the Patient Medical Record Review tool used by GAHAR surveyors, or other forms to record findings, including whether documentation elements are met, partially met, or not applicable.
- The completeness, accuracy, and uniformity of medical record documentation will be evaluated according to GAHAR standards.
- The survey team leader will define the applicable time frame for record selection based on the type of survey being conducted.
- Surveyors will review the selected records independently, asking for assistance only when clarification is required.
- The surveyor(s) will enter details in the Patient Medical Record Review tools, including the Standard No., EOC No., and Evidence of Compliance documents. The MR. columns represent individual patient medical records being reviewed.
- All findings will be documented and aggregated to assess compliance with accreditation standards and will contribute to the overall scoring and evaluation process.
- If a significant number of findings are observed, they may be considered indicative of system-wide non-compliance.
- The survey team leader will retain all review documentation as part of the evidence supporting survey results.

Supporting standards

- Patient-Centered Care chapter (PCC)
- Assessment and Care Planning chapter (ACT)

- Integrated Care Delivery chapter (ICD)
- Critical and Special Care Services chapter (CSS)
- Medication Management and Safety chapter (MMS)
- Information Management and Technology chapter (IMT)

15). Workforce review and interview session

Aim

The purpose of this session is to assess compliance with GAHAR workforce standards and Egyptian labor laws, including staffing ratios and qualifications; verify the implementation of staff bylaws and hospital policies; evaluate staff competency, training, and staffing adequacy for safe patient care; and conduct interviews to assess staff understanding of their roles and teamwork.

Location:

Room that has been designated as a meeting space by the hospital.

Who should collaborate?

GAHAR Surveyors (All surveyors)

From Hospital

- HR Director
- Medical Director (for physician-specific standards).
- Nursing Director (for nursing ratios/skill mix).
- Department Heads (for department-level staffing validation) (if needed).

Preparation requirements

Document required for review:

The following documents shall be reviewed during this session:

The hospital should provide the list of

- Sample of all staff files (medical, nursing, healthcare practitioners, administrative academic/teaching staff).
- Staffing Plans
- Current staffing roster with roles/FTEs.
- Records supporting compliance with Egyptian MOH nurse-to-patient ratios (e.g., ICU 1:2, general wards 1:5), physician licensing/specialty requirements, and contingency plans for shortages.
- Staff licenses (valid MOH/OGM registration).
- Job descriptions aligned with scope of practice.
- Orientation/training records (including fire safety, and infection control).

- Staff bylaws (approved).
- Disciplinary/grievance procedures.
- Performance evaluation system.
- Contracts (per Law No. 12/2003).
- Overtime/on-call records.
- MOH Decree No. 288/2016 regarding nurse-to-patient ratios
- Continuous education program

For effective preparation, the hospital shall closely review all staff files using the staff file review tools that used by GAHAR surveyor (described below in Annex).

Activities:

- GAHAR surveyors will review a sample of staff files, selected from different staff categories (medical, nursing, healthcare practitioners, and administrative academic/teaching staff). A sufficient number of files representing various staff categories, including appointed, contracted, and outsourced personnel, and visitors.
- GAHAR surveyors shall use the staff file review tools.
- If findings are observed during the file review, the survey team may request additional file samples to substantiate the findings recorded from the initial sample.
- Surveyors may focus on orientation of staff, job responsibilities, and/or clinical responsibilities; experience, education, abilities assessment, ongoing education and training, performance evaluation; credentialing and privileging, and competency assessment.
- There will be two interviews conducted, each in a separate location. one will be conducted with medical staff, and the second will be conducted with nursing staff and other staff.
- A discussion session will be held with the Medical Director and Nursing Director to review and evaluate the medical and nursing organizational structure, bylaws, compliance with national standards or guidelines, the process for granting clinical privileges, peer review activities, staff performance evaluation, and the supervision of trainees if applicable.

Supporting standards:

Workforce Management standards chapter (WFM).

16). Academic, Teaching and Research Review session

Aim

If the scope of the hospital includes education and training activities such as undergraduate medical education, postgraduate professional education, or training programs for residents, house officers, or other healthcare trainees (including nursing trainees), the purpose of the assessment is to explore how the teaching and education system is integrated into the facility's clinical operations. The focus is to ensure that these activities do not affect patient safety, clinical outcomes, or patient rights, while also evaluating how well the hospital organizes its educational processes to ensure the best possible learning experience for trainees.

If the scope of the hospital includes conducting clinical research, the purpose of the assessment is to evaluate the hospital's capacity to facilitate research in alignment with ethical standards and regulations. It aims to ensure that research activities protect patients' rights, maintain confidentiality, and maintain the integrity of the ethical research framework within the healthcare setting.

Location:

At a quiet room/hall that can accommodate the surveyor(s) and participants

Who should collaborate?

GAHAR Surveyors

The assigned surveyor for the teaching and research tracing (other clinical surveyors may join the meetings if notes taken during patient tracers need to be discussed)

From Hospital:

Coordinator(s) of undergraduate medical education as well as professional education and training

Clinical research ethics committee coordinator and hospital clinical research coordinator (if applicable)

Preparation requirements:

- The hospital should identify participants from stakeholders involved in the relevant processes.
- The following supporting documents should be available and reviewed during this session:
  - Hospital mission and strategic plan

- Curriculum of different programs
- Documents related to trainees' schedules, communications, and feedback
- Research policy
- Ethical Research Committee formation document and ethical research bylaws
- List of research projects carried out in the hospital

Activities:

Interactive session:

The surveyor will hold an interactive discussion with the assigned participants focusing on:

- What are the different education and/or training programs carried out in the hospital?
- How does the hospital support the program(s) in terms of resources and facilities?
- How is patient safety integrated within the scope of educational activities?
- What process do trainees follow to express their feedback on the teaching process, patient safety, and the care provided to patients?
- If bedside teaching is within the scope of the program (requiring curriculum revision), how is this arranged? Is there any supervision or monitoring of the clinical teaching?
- How is the curriculum developed?
- What is the process for approving any proposed research?
- What resources does the ethics research committee have to carry out its activities?
- How is confidentiality and patient safety ensured during research?
- What is the process for monitoring the research conducted in the hospital?
- What process is followed if a violation during research is reported?

During the survey, the survey may include interviewing staff involved in bedside teaching, attending a session of bedside teaching if applicable, and interviewing patients who have participated in such sessions.

Additionally, the surveyor may conduct interviews with trainees or educational candidates to assess their experiences and understanding of the educational process.

A clinical researcher may also be interviewed to evaluate their awareness of the hospital's research protocols and consenting process. If applicable, interviews with patients involved in research may be conducted. Furthermore, a review of sample medical records of patients enrolled in research studies will be carried out to assess compliance with ethical and documentation standards.

Supporting standards:

Academic and Teaching Standards (ATH).

17). Additional activities (Survey activities needing further verification):

Aim:

The purpose of this session is to ensure that all survey findings are complete and accurate by identifying any elements that may require further review, clarification, or additional validation.

The team should verify whether any findings require cross-checking, further verification, or additional tracing. This includes identifying areas that may require deeper investigation or involve specific activities or locations that were not visited. In some cases, rechecking may be necessary to confirm compliance with scoring criteria and standards.

18). Final Report Session

Aim

- Integration of results among surveyors and making a consensus about the significant findings
- To prepare a comprehensive survey report summarizing the findings of the on-site survey assessing the hospital's compliance with GAHAR standards.
- To provide the hospital with identified areas for improvement and specific recommendations to enhance performance.
- To highlight challenges the hospital may face in implementing improvements.
- To present findings that require immediate leadership attention, especially for standards that were not met or only partially met.

Location:

A quiet, private space large enough to accommodate all surveyors.

Who should collaborate?

GAHAR Surveyors:

Only surveyors are involved in report preparation.

Activities

- The Survey Team Leader will collect all findings and recommendations from the surveyors, reviewing written reports and holding internal meetings to ensure completeness and consistency.
- Any non-compliant standards or gaps identified will be addressed with the surveyors.
- The Survey Team Leader will write the initial report, summarizing findings and recommendations, and discuss these findings with the survey team to ensure accuracy.
- The finalized report will be shared and discussed with the hospital's senior leadership, highlighting key findings and recommendations and addressing any concerns.
- Surveyors may request additional information from hospital representatives during the session as needed.

19). Exit conference

Why will it happen?

The closing session aims to thank the hospital team for their collaboration, summarize key survey findings, acknowledge notable strengths, identify areas for improvement, address any outstanding concerns, and outline the next steps in the accreditation process, while reinforcing a commitment to continuous improvement and promoting open, respectful communication between the surveyors and hospital leadership.

Location

Senior leader may invite staff to attend in a workspace large enough to accommodate the attending staff.

Ensure the room is set up with the required technology and seating arrangements that support clear communication and engagement.

Who should collaborate?

GAHAR Surveyors (All surveyors)
From Hospital

- Hospital leaders: Hospital Director, Medical Director, Nursing Director, Administrative Director, Operations Director, and other executive team members
- Department Heads representing clinical, administrative, and support departments
- Quality Manager, Quality Coordinators, and Patient Safety Officers
- Survey Coordinator
- Frontline staff, such as selected representatives from nursing, medical, and allied health teams

Activities

Surveyors will welcome attendees and thank the organization for their cooperation throughout the survey, outline the meeting agenda, and provide a summary of survey activities such as document reviews, staff interviews, and facility tours, as well as review GAHAR survey findings.

They will highlight the hospital's strengths aligned with accreditation standards, identify areas needing further attention with specific examples, and address any immediate patient safety concerns or significant non-compliance. Suggest best practices or resources to support improvement efforts along with clarification of the next steps and timeline for the formal survey report. The session will encourage questions and open communication to ensure transparency.

C. Post-survey activities

GAHAR Accreditation Status

Duration of Sending the Official Report – Final Accreditation Status of the Hospital: Passing or not:

- The hospital will be notified of the evaluation result and the accreditation status within 15 days of the completion date of the survey visit.
- The final accreditation evaluation result of the hospital is determined based on its compliance with GAHAR standards. GAHAR will send the hospital an official survey report within a maximum of 60 working days from the date of completion of the survey visit. The report will include the evaluation result issued by the Accreditation Supreme Committee, along with any required focus surveys.
- The hospital will receive the accreditation certificate within 30 days from the date of the evaluation result announcement. GAHAR Golden Seal will also be provided, along with rules of using the seal of GAHAR Accreditation, as published on the official GAHAR website.
- If the hospital does not pass the onsite survey, visit, and accreditation is not granted due to the hospital's failure to meet the necessary standards, a six-month grace period will be provided to address the deficiencies, after which the facility will be re-evaluated for accreditation.

Focus Survey and Corrective Action Activities

The General Authority of Healthcare Accreditation and Regulation conducts focus surveys for investigative focus for different reasons:

1. Completion of the accreditation period in case of conditioned accreditation.
2. Conducting further external studying in case of hospitals submitting an appeal.
3. Ensuring compliance with related standards in case of any changes in the scope of services provided or increasing the volume of an existing service.

According to the reasons mentioned above, there are 3 types of focus surveys:

1. Period Completion focus surveys.
2. Appeal focus surveys.
3. Scope change focus surveys.

In the case of focus surveys, the surveyor evaluates the following:

1. Standards scored as not applicable (NA) during the first evaluation survey that become met during the focus survey.
2. Standards scored as not met (NM) and partially met (PM) during the first evaluation survey.
3. Fully met (M) criteria if noncompliance is discovered, as the surveyor is not restricted to items 1 and 2 alone.

Decision-Making Rules:

The Supreme Accreditation Committee applies one of the following decision-making rules in cases of focus surveys:

1. Decision-Making Rules following period completion focus surveys:
   - A decision is made according to the first decision rule for accreditation. This means the facility continues the accreditation period if the evaluation of the focus survey aligns with the conditions of the first decision rule for accreditation.
2. Decision-Making Rules following appeal focus surveys:
   - A decision is made after the acceptance of an appeal related to an accreditation survey according to the same decision-making rules for accreditation.
   - A decision is made after the acceptance of an appeal related to a focus survey for accreditation according to the same decision-making rules following period completion focus surveys.
3. Decision-Making Rules following scope change focus surveys:
   - First: In the case of a modification / addition to the service scope in the same building or a new building, a focus survey is conducted to review a package of standards (determined by the Accreditation Supreme Committee), depending on the type and nature of the added services. The decision-making rules following period completion focus surveys are applied.
   - Second: In the case of combining an accreditation visit with a scope change focus survey in the same building or a new one, a full regular visit for accreditation is conducted, and decision-making rules for accreditation are applied.
   - Third: In the case of combining a period completion focus survey with a scope change focus survey in the same building or a new one, a focus survey is conducted as per the usual procedure for the period completion focus survey, in addition to reviewing a package of standards (determined by the Accreditation Supreme Committee), depending on the type and nature of the added services. The decision-making rules following period completion focus surveys are applied.

Feedback on the Survey

GAHAR is committed to providing the highest quality of service to hospitals. GAHAR survey and questionnaire are an essential part of this commitment. By receiving feedback from hospitals, GAHAR can ensure that its accreditation program meets the needs of hospitals and is continuously improving.

After the survey, hospitals that have been surveyed provide feedback on the survey process, the performance of the surveyors, and GAHAR standards through GAHAR survey questionnaire and communication. The questionnaire covers the full accreditation experience from the initial registration and application phase to the completion of the on-site survey. The facility is expected to complete and submit it within two weeks. The facility completes and responds within two weeks to ensure timely incorporation of feedback into ongoing quality improvement efforts.

Additionally, the questionnaire provides an opportunity for facilities to report any concerns, complaints, or challenges met during the accreditation process, enabling GAHAR to take appropriate corrective actions where necessary.

Accreditation Continuation Process

The accreditation continuation process is the ongoing process of ensuring that the hospital continues to meet the requirements of the accreditation standards.

For hospital, this process typically includes:

- Hospitals must conduct regular self-assessments using GAHAR self-assessment tool to identify any areas where they may not be in compliance with the accreditation standards.
- Hospitals must respond to any inquiries from GAHAR in a timely manner.
- During the three-year period between on-site surveys, GAHAR requires accredited hospitals to inform GAHAR of any change in the field of services provided (adding a new service, cancelling an existing service, or increasing the volume of an existing service by more than 20%) in writing to the e-mail reg@gahar.gov.eg in accordance with Standard **APC.01**.

At least one month prior to the actual implementation of this change, this ensures that GAHAR is kept up to date and able to evaluate the impact of such changes on the hospital's compliance with accreditation standards and its accreditation status.

GAHAR actively sustains the accreditation process by monitoring the ongoing performance of accredited healthcare facilities. GAHAR's Central Administration for Healthcare Regulation conducts unannounced audit visits to accredited hospitals to prepare reports that reflect the level of performance of these facilities and to assess and monitor compliance with GAHAR accreditation standards throughout the three-year accreditation period. These visits are

conducted to ensure that hospitals maintain compliance by reviewing the implementation of accreditation standards in healthcare delivery and promoting a culture of excellence across accredited healthcare organizations, aiming to ensure the quality of healthcare services and support continuous improvement, in accordance with the responsibilities outlined under Law No. 2 of 2018 of the Universal Health Insurance System.

Unannounced Audit Visits

Unannounced audit visits are an important part of GAHAR's accreditation process. They help ensure that hospitals provide high-quality care, maintain the patient's safety, and promote provider satisfaction.

Regulation visits include all healthcare facilities accredited by GAHAR as well as all healthcare professionals working in those facilities. It also includes all stakeholders in the universal health insurance system, including patients and employees of the service-providing institutions.

Purpose of Unannounced Audit Visits

Unannounced visits are conducted to verify the implementation of corrective action plans submitted by accredited hospitals in response to survey visit reports and root cause analysis of reported sentinel events.

Auditors review documentation and records to ensure their accuracy and alignment with accreditation standards. They also assess the organization's compliance with GAHAR standards, helping identify gaps in performance and supporting the implementation of corrective actions to drive improvement. Additionally, by conducting interviews with staff and patients, auditors evaluate staff awareness of accreditation requirements, relevant facility policies, and compliance with patient rights.

Following the visit, auditors compile their findings into a report, highlighting any issues related to GAHAR accreditation standards and relevant laws and regulations. Hospitals are required to submit corrective action plans in response to the audit findings. Follow-up visits may be scheduled to verify compliance, and all responses must be submitted within a predefined timeframe via email.

Types of Unannounced audit visits

There are many types of audit visits to accredited healthcare organizations, including:

Technical and Clinical Audit Visits:

Conducting technical and clinical audit visits, with a primary focus on patient-centered standards, these audits facilitate a structured assessment of compliance with accreditation standards, enable the identification of performance gaps, and reinforce a culture of continuous improvement. Through this process, healthcare organizations are better enabled

to improve patient outcomes, ensure service excellence, and achieve operational efficiency.

Regular audits not only maintain compliance with accreditation standards but also promote transparency, accountability, and a culture of continuous quality improvement. Hospitals are required to submit corrective action plans in response to audit findings within 10 days via tech.regulation@gahar.gov.eg.

Administrative audit visits:

Conducting administrative audit visits aims to assess the compliance of accredited healthcare organizations with organization-centered standards, relevant laws and regulations in the standards, and hospital policies and procedures. This includes governance, management, administrative processes, and environmental and facility safety functions related to GAHAR organizational-centered standards.

Hospitals are required to submit corrective action plans in response to the findings within 10 days via email.

Focused audit visits:

Evaluation may focus on certain functions, departments, or processes within accredited hospitals. For example, the Emergency Department may be selected based on relevant standards or due to findings from the initial audit that indicate specific processes require further investigation.

Focus audit visits are important for focusing on specific areas; these audits provide valuable insights that can lead to meaningful improvements. Hospitals are required to submit corrective action plans in response to the findings within 10 days via email.

Follow-Up Visits

Follow-up visits are planned to verify the implementation and effectiveness of corrective actions taken in response to findings identified during previous survey and audit visits. These follow-up activities are essential for ensuring sustained compliance and promoting continuous quality improvement. Follow-up visits may be conducted to for technical, administrative, and focus audits.

Visits in response to referrals:

These visits are primarily conducted to investigate complaints and critical incidents. The main purpose of the audit visit is to collect information related to specific complaints received from stakeholders, assess their validity, and evaluate the organization's response mechanisms. This process is essential for identifying areas for improvement.

Administrative inspection visits:

In accordance with Law No. 2 of 2018, GAHAR routinely conducts administrative inspection visits to ensure compliance with applicable laws and regulations. Unannounced administrative inspection visits are carried out at accredited healthcare facilities to verify compliance with legal and regulatory requirements related to service provision.

This includes, but is not limited to, licensure, human resources management, GAHAR registration of healthcare providers, supply chain management (procurement, contracts, warehousing, and inventory management), and claims management. Healthcare organizations are required to submit corrective action plans in response to the findings within 10 days via Admin.regulation@gahar.gov.eg.

For further information, see the Healthcare Regulation Rules, published on GAHAR official website.

Patient medical record review tool

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
PCC.04	2	The patient's or legal representative's approval and consent to being hospitalized is recorded in the patient record.											
PCC.07	4	Patient education activities are recorded in the patient's medical record.											
PCC.09	4	A new consent is recorded in the patient's medical record when indicated.											
PCC.10	3	Informed refusal form is recorded and kept in the patient's medical record.											
PCC.12	2	Patient needs and preferences are documented in the patient's medical record.											
ACT.03	4	The patient's identifiers are recorded in the patient's medical record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
ACT.04	4	When patient care is required during the admission process, the care plan is recorded in the patient's medical record.											
ACT.07	3	The patient's medical record identifies the physician responsible for care.											
ACT.09	5	The process of requesting, communicating, and responding to second opinion requests is recorded in the patient's medical record.											
ACT.10	5	Information exchange between consultation requestor and responder to consultation requests is comprehensive and recorded in the patient's medical record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
ACT.11	5	Information exchange between multidisciplinary management teams describes the patient's conditions and important findings and is recorded in the patient's medical record.											
ACT.12	5	Requirements for transporting patients in critical conditions are identified, used, and recorded in the patient's medical record.											
ACT.14	3	The discharge, temporary discharge, referral, and/ or transfer-out orders are clearly recorded in the patient's medical record.											
ACT.14	5	The referral feedback is reviewed, signed, and recorded in the patient's medical record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
ACT.15	3	A copy of the discharge summary is kept in the patient's medical record.											
ICD.02	3	Pre-hospital care records are complete and kept in the patient's medical record.											
ICD.03	5	Medical records of emergency patients include Items from i) to viii) in the intent.											
ICD.05	4	The assessment and reassessment are recorded in the patient's medical records.											
ICD.05	5	The plans of care and follow-up instructions are recorded in the patient's medical records.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
ICD.06	3	Initial medical assessments are performed within 24 hours of hospitalization or more frequently as per patient needs and recorded in the patient's medical record.											
ICD.06	5	Medical reassessments are performed, as per the policy, and recorded in the patient's medical record.											
ICD.07	5	Nurses' assessment and reassessment are timely recorded in the medical records.											
ICD.09	5	Pain screening, assessment, pain management plan, and reassessment are documented in the patient records.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
ICD.10	3	The hospital assesses and reassesses all inpatients for risk of fall using appropriate tools suitable for the patient population and documented in the patient's medical records.											
ICD.10	6	General measures and tailored care plans are recorded in the patient's medical record.											
ICD.11	5	General measures and tailored care plans are recorded in the patient's medical record.											
ICD.12	5	Tailored care plans based on individual patient VTE risk assessments are conducted and recorded in the patient files.											
ICD.13	5	The patient's nutritional needs assessment and management is recorded in the patient's medical record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
ICD.14	4	Special patient populations' needs assessment, and management is recorded in the patient's medical record.											
ICD.15	2	The plan of care addresses all the elements mentioned in the intent from a) to g) and is documented in the patient medical record.											
ICD.20	3	Indication for transfusion is recorded in the patient's medical record.											
ICD.21	4	Monitoring of the patient's condition during transfusion is recorded in the patient's medical record.											
ICD.22	4	Recognition and response to clinical deterioration are recorded in the patient's medical record.											
CSS.01	5	Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
CSS.03	4	Management and use of tubes and catheters are recorded in patient medical records.											
CSS.04	5	Terminally ill patients' assessment, reassessment, and management are recorded in the patient's medical record.											
CSS.05	6	Management of cardio-pulmonary arrests is recorded in the patient's medical record.											
CSS.07	5	Assessment, plan of care, monitoring of progress, and discharge instructions are documented in the patient's medical record.											
CSS.08	5	Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
CSS.09	5	Assessment, reassessment, plan of care, CTG (cardiotocography), Partogram, pain management, and delivery summary are documented in the patient's medical record.											
CSS.10	4	Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.											
CSS.12	5	Restraints and seclusions are recorded in the patient's medical record.											
CSS.13	4	Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.											
CSS.14	4	Pre-transplantation evaluation and post-transplantation care plan are recorded in the patient's medical record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
DAS.04	6	When an additional or substituted examination is called for, medical imaging diagnostic service staff member informs patients and referrers and document it in patient's medical record.											
DAS.08	3	Complete medical imaging and ancillary studies are recorded in the patient's medical record.											
SAS.03	4	The identified risks of the patient's conditions are documented in the patient's medical record before surgery or invasive procedure.											
SAS.04	3	The focused assessment is documented in the patient's medical record.											
SAS.08	3	The report is kept in the patient's medical record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
SAS.10	4	The examination results are available in the patient's medical record within the defined time frame.											
SAS.16	4	The pre-anesthesia assessment and the anesthesia plan are recorded in the patient's medical record.											
SAS.16	5	Immediate pre-induction assessment is performed by the anesthesiologist and recorded in the patient's medical record.											
SAS.17	3	The results of the monitoring are recorded in the patient's medical record regularly according to the approved professional practice guidelines/ protocols.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
SAS.18	2	The implemented anesthesia care is recorded in the patient's medical record, including all elements from a) to k) in the intent.											
SAS.18	3	A copy of the anesthesia record is kept in the patient's medical record.											
SAS.20	2	The patient's physiologic status is monitored during post-anesthesia care, according to professional practice guidelines, and recorded in the patient's medical record.											
SAS.20	4	The provided post-anesthesia care from a) to k) in the intent is recorded in the patient's medical record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
SAS.22	4	The pre-procedural sedation assessment and the procedural sedation plan are recorded in the patient's medical record.											
SAS.23	5	Procedural sedation record is kept in the patient's medical record.											
SAS.24	3	The provided post-procedural sedation care is recorded in the patient's medical record, including items from a) to g) in the intent.											
ATH.09	3	Signed patient consent for participation in research is placed in the research file and the patient's medical record.											

Medical Staff file review tool

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.04	1	There is a job description for every position.											
WFM.04	2	Job descriptions address each position's responsibilities, required qualifications, and reporting structure.											
WFM.04	4	The job description is signed by the staff and kept in the staff's file.											
WFM.05	1	Required credentials for each position are collected and kept in staff files, including independent practitioners' files.											
WFM.05	3	Primary source verification is uniformly applied for all required credentials.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.05	4	Credible efforts are utilized for the verification from the primary sources either directly or through a third party.											
WFM.06	1	The hospital has an approved policy to maintain and standardize staff files that address at least elements from a) through f) in the intent.											
WFM.06	4	Staff files include all the required records from i) through vii), as mentioned in the intent.											
WFM.07	1	A general orientation program is performed, and it includes at least the elements from a) through f).											
WFM.07	2	A department orientation program is performed, and it includes at least the elements from g) through i).											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.07	3	A job-specific orientation program is performed, and it includes at least the elements from j) through m).											
WFM.07	4	All New staff members, including contracted and outsourced staff, attend the orientation program regardless of employment terms.											
WFM.07	5	There is evidence that each staff member has completed the orientation program, which is recorded in their file.											
WFM.08	1	There is a continuous education and training program for all staff categories that may include elements in the intent from a) through m).											
WFM.08	3	The educational program is based on the training needs assessment of the staff.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.09	1	Performance and competency evaluation is performed at least annually for each staff member.											
WFM.09	3	Performance and competency evaluation is based on the job description.											
WFM.09	4	There is evidence of employee feedback on performance and competency evaluation.											
WFM.09	5	Actions are taken based on a performance review.											
WFM.11	4	The appointment decisions and recommendations are approved by a relevant council/committee and/or by the medical director.											
WFM.12	3	Physicians' and dentists' files contain personalized recorded clinical privileges, including renewal when applicable.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.13	1	Ongoing professional practice evaluation (OPPE) of the medical staff is performed at least annually.											
WFM.13	3	The evaluation utilizes objective data to measure achievement in clinical care provision, clinical outcome, and attitude and behavior.											
WFM.13	4	Performance evaluation results are used to improve individual medical performance.											
WFM.13	5	The results will be used to help decisions related to re-privileging, re-credentialing, and reappointment.											
WFM.14	5	Results/reports of peer review are used for reappointment and re-privileging.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
OGM.08	1	There is a job description for each hospital leader to identify the required qualifications and responsibilities.											
OGM.08	2	The responsibilities of the hospital leaders include at least a) through d) in the intent.											
OGM.09	1	There is a job description for each department/ services supervisor to identify the required qualifications and responsibilities.											
OGM.09	2	There is a supervisor for each department of the hospital who is qualified as required by the job description.											
OGM.09	3	The responsibilities of the departments/ services supervisor include at least a) to h) in the intent.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
OGM.17	5	All test results, immunizations, post-exposure prophylaxis, and interventions are recorded in the staff's health record.											
IMT.05	5	There is a signed confidentiality agreement in each staff member's personal file											
IMT.07	3	The information confidentiality is maintained during the retention time											

Nursing Staff file review tool

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.04	1	There is a job description for every position.											
WFM.04	2	Job descriptions address each position's responsibilities, required qualifications, and reporting structure.											
WFM.04	4	The job description is signed by the staff and kept in the staff's file.											
WFM.05	1	Required credentials for each position are collected and kept in staff files, including independent practitioners' files.											
WFM.05	3	Primary source verification is uniformly applied for all required credentials.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.05	4	Credible efforts are utilized for the verification from the primary sources either directly or through a third party.											
WFM.06	1	The hospital has an approved policy to maintain and standardize staff files that address at least elements from a) through f) in the intent.											
WFM.06	4	Staff files include all the required records from i) through vii), as mentioned in the intent.											
WFM.07	1	A general orientation program is performed, and it includes at least the elements from a) through f).											
WFM.07	2	A department orientation program is performed, and it includes at least the elements from g) through i).											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.07	3	A job-specific orientation program is performed, and it includes at least the elements from j) through m).											
WFM.07	4	All New staff members, including contracted and outsourced staff, attend the orientation program regardless of employment terms.											
WFM.07	5	There is evidence that each staff member has completed the orientation program, which is recorded in their file.											
WFM.08	1	There is a continuous education and training program for all staff categories that may include elements in the intent from a) through m).											
WFM.08	3	The educational program is based on the training needs assessment of the staff.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.09	1	Performance and competency evaluation is performed at least annually for each staff member.											
WFM.09	3	Performance and competency evaluation is based on the job description.											
WFM.09	4	There is evidence of employee feedback on performance and competency evaluation.											
WFM.09	5	Actions are taken based on a performance review.											
WFM.15	1	The nursing director is qualified and has approved job description outlines responsibilities from a) to d) in the intent.											
WFM.15	3	Nurses not fully employed by the hospital follow the same credentialing process.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.16	1	Licensure, education, training, and experience of other healthcare practitioners are used to make clinical work assignments.											
OGM.08	1	There is a job description for each hospital leader to identify the required qualifications and responsibilities.											
OGM.08	2	The responsibilities of the hospital leaders include at least a) through d) in the intent.											
OGM.09	1	There is a job description for each department/ services supervisor to identify the required qualifications and responsibilities.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
OGM.09	2	There is a supervisor for each department of the hospital who is qualified as required by the job description.											
OGM.09	3	The responsibilities of the departments/ services supervisor include at least a) to h) in the intent.											
OGM.17	5	All test results, immunizations, post-exposure prophylaxis, and interventions are recorded in the staff's health record.											
IMT.05	5	There is a signed confidentiality agreement in each staff member's personal file											
IMT.07	3	The information confidentiality is maintained during the retention time											

Other healthcare professional Staff file review tool

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.04	1	There is a job description for every position.											
WFM.04	2	Job descriptions address each position's responsibilities, required qualifications, and reporting structure.											
WFM.04	4	The job description is signed by the staff and kept in the staff's file.											
WFM.05	1	Required credentials for each position are collected and kept in staff files, including independent practitioners' files.											
WFM.05	3	Primary source verification is uniformly applied for all required credentials.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.05	4	Credible efforts are utilized for the verification from the primary sources either directly or through a third party.											
WFM.06	1	The hospital has an approved policy to maintain and standardize staff files that address at least elements from a) through f) in the intent.											
WFM.06	4	Staff files include all the required records from i) through vii), as mentioned in the intent.											
WFM.07	1	A general orientation program is performed, and it includes at least the elements from a) through f).											
WFM.07	2	A department orientation program is performed, and it includes at least the elements from g) through i).											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.07	3	A job-specific orientation program is performed, and it includes at least the elements from j) through m).											
WFM.07	4	All New staff members, including contracted and outsourced staff, attend the orientation program regardless of employment terms.											
WFM.07	5	There is evidence that each staff member has completed the orientation program, which is recorded in their file.											
WFM.08	1	There is a continuous education and training program for all staff categories that may include elements in the intent from a) through m).											
WFM.08	3	The educational program is based on the training needs assessment of the staff.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
WFM.09	1	Performance and competency evaluation is performed at least annually for each staff member.											
WFM.09	3	Performance and competency evaluation is based on the job description.											
WFM.09	4	There is evidence of employee feedback on performance and competency evaluation.											
WFM.09	5	Actions are taken based on a performance review.											
WFM.16	1	Licensure, education, training, and experience of other healthcare practitioners are used to make clinical work assignments.											
OGM.08	1	There is a job description for each hospital leader to identify the required qualifications and responsibilities.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
OGM.08	2	The responsibilities of the hospital leaders include at least a) through d) in the intent.											
OGM.09	1	There is a job description for each department/ services supervisor to identify the required qualifications and responsibilities.											
OGM.09	2	There is a supervisor for each department of the hospital who is qualified as required by the job description.											
OGM.09	3	The responsibilities of the departments/ services supervisor include at least a) to h) in the intent.											
OGM.17	5	All test results, immunizations, post-exposure prophylaxis, and interventions are recorded in the staff's health record.											

STD No.	EOC No.	Evidence of compliance	MR.1	MR.2	MR.3	MR.4	MR.5	MR.6	MR.7	MR.8	MR.9	MR.10	Score
IMT.05	5	There is a signed confidentiality agreement in each staff member's personal file											
IMT.07	3	The information confidentiality is maintained during the retention time											

الجـــودة
مســـــار
إجبـــاري

gaharegypt