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This Manual, prepared in the Sector Unit for Standardization in Healthcare after an extensive consensus process and with the participation of experts from the Ministry of Social Protection, Icontec and institutions participating in the Sector Committee, has been updated to respond to the new requirements of international standards and the need to encourage institutions to new developments in quality processes that emphasize the approach towards obtaining patient-centered outcomes.

A new set of support standards, “Management of Technology,” has been incorporated as well as two new care subgroups, “Patient safety” and “Network Integrated Offices.” Improving standards became a group that interacts with standards of care and with support standards with the purpose of increasing its systemic and comprehensive approach and its impact on the culture of quality and patient safety. Specific new standards of humanization, promotion and prevention, together with dental standards and others for university hospitals are also incorporated.

Superior quality requirements were integrated in this process in a continuum of care to the user, making the implementation process simpler, but no less demanding for institutions.

Subsequently, this new Manual allows us to begin the process of international accreditation of the accreditation standards of our Single Health Accreditation System.

All this work becomes the tool for excellence that will gain standing as institutions, both accredited and those undergoing self assessment processes, take ownership of it and focus on optimizing the results already achieved and obtain new ones in the care of their patients. Institutions can identify, with the help of these standards, the processes that add value, discard the inefficient processes, and define, through properly performed measurements, the scope of the results to be obtained both in clinical aspects and in the recovery of function of the patient. Ultimately, patients will express their satisfaction of being treated with quality and safety.

Beatriz Londoño Soto
Deputy Minister of Health and Welfare, October 2011
The Manual of standards for accreditation of institutions providing health services presents the guidelines that will direct the process of accreditation for hospital and outpatient institutions and relevant accreditation standards.

The standards are based on a systemic approach that understands health care as user- and family-centered, in continuous quality improvement and risk focused. All standards must be understood from the perspective of risk focus (identification, prevention, intervention, reduction, impact) and the promotion of excellence.

Consistent with the approach of continuous quality improvement, for an institution to achieve the category of healthcare accredited, it should not only exhibit good processes and/or structure, these need to become user-centric health outcomes.

This Manual contains the following new features:

- Integration of outpatient and hospital manuals
- Inclusion, as subgroups, of standards for network integrated offices, and as a group, technology management
- New standards of patient safety
- New standards of humanization of service
- New standards for evaluating the teaching-service relationship and the status of the university hospital
- New standards of oral health
- New standards for promotion and prevention
- Improvements and additions to the wording in some standards and criteria
- Improving standards in the clarity of intent of the total set of standards to which they belong
- Details on the evaluation model
- Inclusion as a new group of standards for quality improvement
- Details for the implementation transition period

Sector Unit Council for Standardization in Healthcare
14 July 2011
METHODOLOGY FOR PREPARATION

METHODOLOGY

• The work was based on existing manuals approved by Resolution 1445 of 2006 for hospitals, outpatient institutions, clinical laboratories and imaging.
• Groups of technical experts from the Ministry of Social Protection, Icontec and hired companies:
  • Proposed unification of standards into a single manual.
  • Proposed accreditation standards for promotion and prevention activities.
  • Proposed patient safety standards based on the recommendations of the technical guide on best practices in patient safety (Guía técnica en Buenas Prácticas en Seguridad del Paciente).
• A survey was taken of 59 public health care institutions (IPS) that were in the process of preparing for accreditation on their opinion on the issuance of a single manual. 96% of IPS respondents said they completely agreed and also agreed with the strategy of the USNS to simplify self-assessment and improve understanding of accreditation standards with the enactment of a single manual of standards for accreditation.
• The manual was submitted and approved at the Council of the Unit Sector for Standardization in Healthcare on 14 July 2011.
### Consensus process

The Accreditation Standards Committee was initiated in 2008, holding seven meetings attended by 240 people that represented health care institutions, insurance companies, academia, scientific societies and independent professionals of the public and private sectors.

The professionals involved in the consensus process in the Accreditation Standards Committee of the Sector Unit for Standardization in Healthcare represented the following institutions:

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1. PURPOSE AND SCOPE

This Manual applies to health care institutions that provide outpatient services, inpatient services, or both. Not included are institutions providing habilitation and rehabilitation, which will be assigned a specific manual for this type of institution.

Similarly, in the case of clinical laboratories and institutions providing imaging services exclusively, they shall have a specific manual for this kind of entity.

There is a column in front of each standard where the institution must specify, in its self-assessment, whether the standard applies to it or not. This decision, prior to assessment, must be agreed with the accrediting body at the time of application in order to obtain accreditation certification.
2. ENTRY REQUIREMENTS

Accreditation standards require basic conditions to be in place to allow the support of excellence; these have been called entry requirements. Without the satisfaction of these requirements, it is not possible for an institution to start the application cycle for granting accreditation.

These entry requirements are defined by the Ministry of Social Protection, together with the healthcare accrediting organization, with the prior opinion of the Technical Council of Sector Unit for Standardization in Healthcare.
3. GLOSSARY

The user may find the glossary that has been agreed by consensus with the terminology committee of the Sector Unit for Standardization in Healthcare in the Health Care Quality Observatory, which can be consulted at the link: http://www.minproteccionsocial.gov.co/ocs
4. EXPLANATION OF THE MANUAL STRUCTURE AND ORDER OF THE STANDARDS

4.1 GROUPS OF STANDARDS

The standards are arranged as follows: a first section contains the Group of Standards of the Healthcare Customer Process; a second section which are groups of Standards for Administration-Management Support to these care processes; and a third section which includes the standards for improved quality.

The first section is designed in accordance with the generic patient care process in a hospital or outpatient facility. It comprises the standards subgroups of: patient rights, patient safety, access, registration and admission, needs assessment on admission, care planning, treatment delivery, assessment of care, referral, exit, and monitoring, and counter referral. It ends with the Network Integrated Offices subgroup, which includes the processes of articulation of the different venues based on top quality management proposed by the health accreditation.

The second section includes the administration-management standards processes that are critical to the organization to support healthcare processes. This section is divided into six groups of standards:

- **Directing**: this is the work to be performed by the organization in relation to its strategic planning process and the role of the organization’s governing bodies.
- **Management**: this is the work of the functional units and government bodies of the institution in relation to the different key areas and functions that the institution must continuously develop.
• **Human Resource Management**: this focuses on talent management, from planning to retirement, and the process of continuous improvement.

• **Information Management**: this focuses on the integration of all care and administrative areas in relation to clinical and administrative information and its use for decision making at all levels of the organization.

• **Physical Environment**: this includes the decisions and processes that must be taken into account in the organization so that the functionality of the structure cooperates with the proper functioning of healthcare processes.

• **Technology Management**: this focuses on the comprehensive management of all technological resources, from planning to renewal, and the analysis of the effects of their use.

The third section of standards consists of the five standards of quality improvement that apply to all processes evaluated both in healthcare and in support standards.

**Figure 1. Graphical Conception of the Groups of Standards**

**4.2 PROLOGUES**

Each group of standards is preceded by a prologue, which aims to explicitly present the intent with which each group has been designed.

This in order to guide the institution’s self-evaluation and explicitly define the field of assessment by the accreditation assessor during the application cycle in order to obtain health care accreditation certification.
Some standards include criteria, which refer to specific conditions that must be studied by the organization to consider that it meets the requirements in accordance with the intent of each standard. In other words, it serves the purpose of “do not forget.”

4.3 CRITERIA AND STANDARDS
Each standard is in bold, with a numbering that identifies the position of the standard in the Manual. Then there is a code that defines the group or subgroup of standards where it is located, allowing to identify similar standards between different manuals. The evaluation of organizational performance for granting accreditation is done according to the standard.

Some standards include criteria, which refer to specific conditions that must be studied by the organization to consider that it meets the requirements in accordance with the intent of each standard. In other words, serves the purpose of “do not forget.”

4.4 IMPROVEMENT STANDARD OF THE GROUP OF STANDARDS
At the end of each group of standards is an improvement standard that aims to assess the extent to which the requirements of the standards of the improvement group are operational in the processes evaluated by the specific group.
5. THE EVALUATION MODEL

5.1 THE MODEL
The standards in this manual are designed to be evaluated through a process bearing the following characteristics:

a. *Outcomes-oriented evaluation focused on the patient/client:* It demonstrates how the institution is achieving them through performance, focusing on processes or structures highly correlating with the outcome.

b. *Evidence of the behavior of measurable elements:* the evaluation methodology aims to find and qualify compliance standards by evidence of the behavior of measurable elements.

c. *The evaluator should focus on the “what,” leaving the “how” to institutions:* the methodology evaluates how institutions have implemented processes for compliance with standards, respecting their autonomy to choose the most appropriate approach according to their specific conditions.

d. *Monitoring tracer patients:* the primary method for finding the evidence is based on monitoring tracer patients. This methodology evaluates the care cycle of a user in health services and organizational performance, which should occupy most of the time in the evaluation or self-evaluation. The remaining time can be used to continue employing the current verification techniques: meeting with teams, review of documentation, visit to facilities and interviews with users and associates.
6. TRANSITION PERIOD

The transition period acknowledges that the average preparation time of an institution for accreditation in Colombia is around three years. Therefore, it has been established that the institution in the process of accreditation should not lose its progresses, but instead have a reasonable time to apply for accreditation without leaving behind their developments or create sudden changes in their process. Concurrently, institutions that so wish will be allowed to advance immediately to the higher levels of demand required in this manual.

The rules of the transition period are:

a. Institutions preparing for accreditation that have conducted self-evaluation processes under the accompanying manuals of Resolution 1445 of 2006 will have an 18-month term, from the issuance of the resolution adopting the single manual, to report to the external evaluation process before the accrediting body. During this transition period, the institutions may report with the manual established by Resolution 1445 of 2006 or the new manual.

b. To obtain accreditation, the complete cycle (granting and two follow-ups) will be done according to the manual of Resolution 1445 of 2006, and the institution may voluntarily request evaluation of initial granting with this manual.

c. Entities that are accredited upon issuance of the resolution adopting the new manual may request that their monitoring be made with this manual or may wait until the new granting cycle.
d. Accredited institutions that complete their full accreditation cycle in the 18-month span following the issuance of the resolution adopting this manual may apply for renewal of accreditation with the manuals of Resolution 1445 of 2006.

The institutions preparing for accreditation that have conducted self-evaluation processes under the accompanying manuals of Resolution 1445 of 2006 will have an 18-month term, from the issuance of the resolution adopting the single manual, to report to the external evaluation process before the accrediting body.
7. ACCREDITATION STANDARDS

Content of the accreditation standards

- Group of standards of the healthcare customer care process
- Group of directing standards
- Group of management standards
- Group of human talent management standards
- Group of physical environment management standards
- Group of technology management standards
- Group of information management standards
- Group of quality improvement standards
7.1 GROUP OF STANDARDS OF THE HEALTHCARE CUSTOMER CARE PROCESS

Standards 1 to 74

- Patients’ rights
- Patient Safety
- Access
- Registration and admission
- Needs assessment on admission
- Planning of care
- Delivery of treatment
- Evaluation of service
- Discharge and monitoring
- Referral and counter-referral
- Network Integrated Offices

INTENTION OF THE GROUP OF STANDARDS OF CARE (AS)
The expected outcome when an institution complies with the standards of this group, from a humane approach to service, is:

- During care, patients’ rights are respected (to information, to accept or reject participation in research, to privacy and confidentiality, to their good name, to making decisions about their body, to the dignity and respect for their beliefs, customs and values, to freedom, etc.) and have each of these rights explained.

- They know their duties in their capacity as users, that respect for and compliance with these duties is fostered and that there are explicit mechanisms for resolving disputes about these definitions. For this, the
institution must design or adopt both rights and duties (in accordance with guidelines recognized nationally and internationally), disclose them to the internal customers and external customers (including strategies for patients, or failing, their families or representatives, to understand them), deploy them within the processes and evaluate respect for them.

- **Patients receive the care offered by the institution, without discrimination, within a reasonable time, without interruption and according to their condition or disease.** To do this, the organization must design care cycles with the interfaces between the constituent processes, routes of patients in the case of networks and various points of care, strategies to remove access barriers there may be, information to be given to guide patients during cycles of care, the possibility of free choice according to institutional availability, service times for access and appointment scheduling. Strategies for the dissemination and deployment of cycles, routes, interfaces, mechanisms of information to patients and waiting times should be developed. Measurement and evaluation strategies should be established of described purposes.

- **Care of the patient and family is conducted in a manner consistent with the individual socio-cultural characteristics, and their needs and expectations of care be consulted.** To this end, the organization must have processes to identify and evaluate these individual sociocultural characteristics of the patient and family, as well as the needs of the patient at the time of admission, and document them so the health team responsible for care knows them and acts accordingly. This includes assessing the educational needs of the patient, assessment of knowledge, expectations, information and education needs of the patient and family about the illness, qualification of the health team responsible for the patient to identify and respond to the needs and expectations, needs related to disease prevention and health promotion and identification of the isolation needs of the patient.

- **Each patient receives attention, care and treatment according to specific health conditions.** To achieve this, the organization must have processes to plan for the attention, care and treatment of each patient. This planning must be based on the best available evidence and define actions for diagnosis and treatment and actions for the implementation, development and monitoring of the plan and informed consent on the care and treatment plan.

- **The patient undergoes the care and treatment plan in conditions of safety, respecting his or her rights, in an informed manner, with educational actions about the disease or health condition and in order to obtain the expected results of care.** For this, the organization must have processes to implement the planned interventions.

- **Implementation of the care and treatment plan is assessed for the patient to achieve the expected results of care.** To this end, the organization must have processes of individual assessment of results, reading the perceptions of patients and their families about the care provided, feedback and adjustment of processes and centralized monitoring if developed within a network.

- **The patient receives adequate treatment completion and plan of care post-discharge.** To do this, the organization must have discharge and follow-up processes.

- **The patient requiring referral is ensured of the conditions for continuity of care in place of referral and, if necessary, return to the institution.** To this end, the organization has general processes to define and implement benchmarks and patient transport conditions, to provide clinical and administrative information to the patient and for the sender, healthcare professional, to know the results and record them in the medical record. It also has specific processes for referral to laboratory and diagnostic imaging, emergency room, provision of medicines, higher complexity outpatient services, hospitalization and promotion and prevention programs. When the institution operates as the receiving entity, it has processes to inform on patient care to the sending entity or professional.

- **The patient will benefit from actions to improve the processes of care and treatment.** To this end, the organization develops a plan to improve processes systematically, based on the continuous quality improvement cycle.
**GROUP OF STANDARDS OF CARE**

**PATIENTS’ RIGHTS**

**Standard 1. Code: (AsDP1)**

The organization has a statement of patients’ rights and duties embodied in the organization’s strategic direction plan, which applies to the customer care process. The staff has been trained in the content of the patients’ statement and has tools for evaluating that they understand and follow these guidelines. Patients who will be cared for know and understand the content of the statement of their rights and duties.

**Criteria:**

- Patients are informed of their rights and, if conditions of the patients do not allow their understanding of the content (infants, mental limitations, etc.), the organization must ensure that they are informed and understood by a companion capable of understanding (version includes foreign languages or dialects used by the user when applicable).
- The organization ensures that the process of care to patients is provided in keeping with the respect for the patient’s condition and independent of sex, age, values, beliefs, religion, ethnicity, sexual orientation or medical condition.
- The organization ensures strategies for the active participation of the patient and family in the care process.
- The functions of the hospital ethics committee include promotion, dissemination and ownership of the duties and rights and it studies the cases in which they are violated.
- User participation in research must have his or her written and explicit acceptance. Prior to this acceptance, the user will be informed verbally and in writing of that request, explaining the scope and risks of participation.
- All research warrants a meeting of a research ethics committee. There must be a guarantee that it met and that it formally approved it by means of a record.
- The refusal of the user may not be barrier to medical care appropriate to user’s condition.
- The organization respects the user’s will and autonomy.

**Standard 2. Code: (AsDP2).**

The institution that conducts research projects with users ensures:

**Criteria:**

- Respect for the user’s right to participate or refusal to do so.
- Information related to the project, its purpose, benefits and risks.
- A committee to discuss and endorse the research projects where the institution is involved.
- The analysis of the adverse events of research studies.
- The technical skills of staff that is part of the research team.
- The ethical principles and international and national parameters for the participation of users or staff in clinical research.

**Standard 3. Code: (AsDP3)**

The organization has a Code of Ethics and Code of Good Governance articulated with the strategic direction. Compliance is evaluated and updated when necessary.

**Criteria:**

- The Code of Ethics includes respect for the rights and duties of users.
- The Code of Good Governance includes mechanisms to present potential conflicts of interest.
- Ethics committees assess special situations of ethical patient care (transplant, brain death, terminal status, among others).
### Standard 4. Code: (AsDP4)

The organization ensures that the accreditation standards applied to the services rendered are likewise met to all users it serves, regardless of the mode of sale or procurement of services.

**Criteria:**

- If the organization provides services by selling partial services such as hotel, operating rooms or other, it has mechanisms to ensure that extra-institutional outpatient or intra-institutional care delivered by third parties is provided in compliance with the accreditation standards regarding the service or services rendered.
- If the organization is responsible for some of the care of populations or contracts services with third parties, it has mechanisms to ensure that the user’s care cycle for which it is responsible is done in compliance with accreditation standards.

### PATIENT SAFETY

### Standard 5. Code: (AsSP1)

The organization has formulated, implemented and evaluated the patient safety policy and ensures deployment throughout the organization by:

**Criteria:**

- A functional structure for patient safety.
- The implementation of strategies for strengthening fair safety culture that encourages voluntary reporting of events, identification of healthcare risks and definition of safety barriers aimed at mitigation.
- Monitoring of adverse events.
- Evidence of trends toward improvement and superior performance

### Standard 6. Code: (AsSP2)

The patient safety policy unfolds in the generation and measurement of a safety culture (including measuring safety climate), the implementation of a security program (which defines the tools) and the formation of the patient security committee. It includes:

**Criteria:**

- The standardization of a search system for risk factors, failures and adverse events.
- Research, analysis, management and decision-making to avoid preventable adverse events and, if they should occur, mitigate their consequences.
- The organization identifies whether the current care is the result of an adverse event, regardless of where the preceding care was provided.

### Standard 7. Code: (AsSP3)

The organization implements all the recommendations that apply to the technical guide of good practices in patient safety in healthcare: safe institutional processes, safe healthcare processes, practices that improve the performance of the professionals, and involve patients and those close to them in their safety.
### ACCESS

**Standard 8. Code: (AsAC1)**

The organization ensures user access according to different features and characteristics of users. Access barriers are evaluated and improvement actions are developed.

| 5 | 4 | 3 | 2 | 1 |

**Criteria:**

- From access, redundant identification mechanisms are defined.
- From access, identification of care risk is made, according to type of user.
- An analysis is made of access barriers to the organization (authorizations, administrative, geographic, etc.) and also within the organization to the different services.
- Unmet demand measurements are made and actions that demonstrate reduction are taken.

**Standard 9. Code: (AsAC2)**

In case of networked integrated organizations, a range of providers or health care points and paths are identified. Access barriers are evaluated and improvement actions are developed.

| 5 | 4 | 3 | 2 | 1 |

**Standard 10. Code: (AsAC3)**

The user care cycle is standardized from admission to the organization until discharge, in the different stages of administrative and care contact. The entire care and administrative staff of the organization knows it. Knowledge is verified and actions are implemented against deviations.

| 5 | 4 | 3 | 2 | 1 |

**Standard 11. Code: (AsAC4)**

When a user requests appointments, the organization guarantees the right of the user to request care with the health professional of the user’s choice. This professional is among the options offered by the provider institution. It has a system that allows checking availability of this professional and the availability for user care.

| 5 | 4 | 3 | 2 | 1 |

**Criteria:**

- Otherwise, it will provide the applicant other options of professionals available, consistent with the needs of the user.

**Standard 12. Code: (AsAC5)**

The organization schedules the service according to the availability of the professionals and in order to respect the users’ time, it schedules taking into account the time required to perform each of the care processes. It does so considering the installed capacity, analysis of demand for services and care processes. This scheduling is evaluated periodically for compliance under quality criteria. Corrective measures are taken when deviations are discovered.

| 5 | 4 | 3 | 2 | 1 |

**Standard 13. Code: (AsAC6)**

The organization defines the availability standards and indicators for outpatient services and hospital response with its own and those that are within or exceed the thresholds defined in the Quality Information System.

| 5 | 4 | 3 | 2 | 1 |
Criteria:

In the event of non-provision of care to user, for any reason, the organization has a system of investigation, analysis and information for the causes of non-provision.

The organization has defined the following access indicators and standards:

- Availability for certain outpatient services that it provides
- Waiting times at different times of access to administrative and healthcare services, including taking of laboratory samples and conducting support examinations (laboratory and imaging)
- Times for inter-consultations
- Waiting lists for conditions that warrant them
- Unmet demand
- Corrective measures are taken when deviations are discovered

### Standard 14. Code: (AsAC7)

The organization ensures the information to the user about the services provided. In cases where the user has no rights, information must be explicit regarding how to access the provision of such non-covered services.

### Standard 15. Code: (AsAC8)

Appointment scheduling and authorization to users who require services are standardized.

Criteria:

- The appointment scheduling system can be based on various methods known in the health system (call centers, telephone services or visits in the respective office, internet, etc.). The organization takes measures to improve the effectiveness of these means.
- The system has the updated databases of users eligible to receive services in the provider entity (ies), if applicable.
- The person who assigns the appointment knows information on: availability of services, hours of operation, professionals, specialties and geographic location of providers where applicants have the right to care.
- Upon assignment of appointment, the user is informed of date, time, address and professional assigned, and how to cancel. Record of this information is left at the place the appointment is assigned.
- The organization has a strategy in place to reduce the risk of nonappearance.
- The organization ensures that information required for care is delivered to user before the service.
- The organization’s flow of information is standardized indicating the procedure to follow for users requesting clinical laboratory tests and diagnostic images or services that do not require an appointment for provision.

### REGISTRATION AND ADMISSION

### Standard 16. Code: (AsREG1)

The process for appointment scheduling, registration, admission and preparation of the user is standardized, whereby the user will be guided on what to do during care. Compliance is assessed and improvement actions are developed where necessary.

Criteria:

- It includes information to the user about aspects concerning registration, accommodation, care and attention, and administrative issues such as tariffs, copayments or moderating fees and documentation required for admission and discharge.
- It includes use of redundant identification controls.
The members of the health team coordinate the following activities upon patient admission:

- Identification of organization staff that will be the responsible for the user
- Redundant user identification mechanisms
- Definition of risks according to condition on admission
- Patients are identified by the health team before any procedure
- Prioritization of patients to be served in all services
- Prioritization of emergency surgeries according to the risk of that condition on the patient’s life
- Identification of patients in the emergency

Mandatory prior preparation of user is standardized in order to undergo the procedures prescribed by the health team and compliance with such preparation is verified. The reception staff should inform the user that is not adequately prepared of the steps to fulfill this requirement. In any case, professionals and technicians of the organization will provide support in case of any doubt.

- The orientation includes receiving documents and instructions to wait for calls or special notices for user care.
- The organization has an advising process for solving problems, in cases where users lack some support or do not comply with all relevant paperwork.
- The organization monitors and makes specific efforts in relation to times for admission to the different care services.
- Checklists for the verification of compliance with criteria are established in accordance with the priorities and risks detected by the institution.
- Corrective measures are taken when deviations are discovered.

**Standard 17. Code: (AsREG2)**

The information to deliver at the time of admission to user and family is standardized.

<table>
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<tr>
<th>Criteria</th>
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<th>4</th>
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<th>1</th>
</tr>
</thead>
</table>

Criterias:

- The organization ensures a process to provide information to the user and family in the following areas:
  - Key personnel to contact if care is required or if concerns are raised about the quality levels provided
  - Routines relating to schedules and restrictions on visits and feeding schedules
  - Security measures, including use of alarms, bells and behavior in a possible evacuation
  - The sequence of events and indications about the place and the professional or professionals who will perform the treatment
  - Rights, services covered and not covered under the Mandatory Health Plan, complementary plans and medicine
  - Location in the room and in the environment
  - Causes of delay and the maximum waiting time
  - Measures to involve the user and family in processes of care safety: information, report of abnormal situations, examples of risk situations, etc.

- Checklists for the verification of compliance with criteria in accordance with the priorities and risks detected are established by the institution.
- Corrective measures are taken when deviations are discovered.

**Standard 18. Code: (AsREG3)**

In the care services there are guidelines and protocols with explicit criteria, which establish the requirements for prior preparation of the patient for carrying out any intervention. These guidelines or protocols:

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<tr>
<th>Criteria</th>
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</tr>
</thead>
</table>

Criterias:

- Are found and used in the respective administrative and care places that require timely information for users
- Are reviewed and adjusted periodically. Each update is sent to the place or service that applies and adherence is monitored.
- A record is guaranteed (physically or on the information system) regarding the recommendations given to the patient for his or her preparation.
- Actions for improvement are disseminated and generated in case of noncompliance.
NEEDS ASSESSMENT ON ADMISSION

Standard 19. Code: (AsEV1)

The organization identifies, evaluates and responds to the educational needs of the users.

Criteria:

• The health team is ready and knows how to perform a culturally congruent care to the target population.
• Information needs are taken into account.
• The assessment of knowledge, expectations and needs for information and education of the patient and family in relation to the illness are fully identified in collaboration with patient, and this includes:
  • Knowledge of the patient about the condition
  • How to treat the disease
  • User expectations about the outcome of the treatment
  • Possible complications and risks
• There is evidence that the needs assessment is conducted by a healthcare team and coordinated by the treating physician.

Standard 20. Code: (AsEV2)

The organization, according to the type of services provided, ensures that the health team has promotion and prevention programs that systematically identify and assess the needs related to disease prevention and health promotion, and answers are provided considering the participation of users.

Criteria:

• Guidelines and/or procedures are secured to assess the need for disease prevention and health promotion for all users regardless of diagnosis, including infection prevention.
  • The need for disease prevention and health promotion is evaluated for each user, especially if it is the first time the user comes into contact with the organization or the health system.
• The need is reviewed in accordance with changes in the patient’s condition or by request of the patient.
  • Identification of the need for disease prevention and health promotion is made considering the social conditions of the user and cultural background.
• The team responsible for the user’s health care knows the user’s needs for disease prevention and health promotion.
  • Comprehensive care strategies that include promotion and prevention programs and remedial actions are developed.
  • Compliance with promotion and prevention programs is evaluated in accordance with current standards, and user adherence and health outcomes are measured.
  • Associates’ adherence to guidelines is evaluated.
  • Actions are taken regarding the deviations of the results obtained.

Standard 21. Code: (AsEV3)

The organization ensures that it is able to identify, from the time of admission itself, if the patient requires special isolation techniques according to pathology.

Criteria:

• Isolation should maintain the dignity of the patient and cannot prevent a care process according to the requirement for the patient’s illness.
• Once the need for isolation is identified, the organization designs a treatment plan, implements treatment and evaluates outcome according to the decision.
• The organization provides mechanisms to prevent the risk of spread of infection.
• The organization conducts ongoing monitoring of adherence to the special techniques for isolation on the part of associates, disseminates its results and stimulates continuous improvement.
• There are techniques and instructions for family and visitors to comply with isolation techniques.
• All persons having direct contact with patients in isolation should be trained to minimize risks to users. This includes the health team, practical training personnel, teachers and researchers, among others.
PLANNING OF CARE

**Standard 22. Code: (AsPL1)**

If the organization has some responsibility for specific population groups, it has health risk management and assessment processes for the population under its responsibility and it establishes mechanisms for training in self-care and co-responsibility.

Criteria:

- Risk approach is defined.
- Critical risks are prioritized.
- Impact is measured.
- Results are managed and evaluated.

**Standard 23. Code: (AsPL2)**

There is an attention, care and treatment planning process for each patient, which includes implementation, development and monitoring of the treatment plan according to the type of service provided.

In any organization, this planning includes:

Criteria:

- The processes involved in the care and treatment are planned taking into account the evidence-based clinical practice guidelines that the organization has developed, adopted or adapted. The protocols and procedures defined by the clinical laboratory, imaging services and other support services are linked to the processes of care and treatment of health care.

- In any of the above options, guidelines should be explicit in containing:
  - The objectives of the guide
  - Identification, classification and interpretation of evidence
  - Definition of consensus mechanisms
  - Record of conflicts of interest of members of the development group
  - Explicit formulation of recommendations
  - How often the update will be conducted
  - Applicability
  - How often and how adherence to the guidance will be monitored, including peer analysis if appropriate and necessary
  - These processes are an integral part of the training, orientation and re-orientation of each worker. There is evidence of knowledge of these processes on the part of employees.
  - The organization has immediate reaction guidelines and management of adverse events that potentially are the result of processes of care.

**Standard 24. Code: (AsPL3)**

In organizations that provide dental services, they offer mechanisms to involve the user as co-responsible for oral care and to contribute to the success of the dental treatment.

**Standard 25. Code: (AsPL4)**

In organizations that provide dental services, mechanisms are guaranteed to corroborate the medical history of the patient and the care and medicines taken, to establish a safe treatment plan jointly or coordinately with the health team.
| Standard 26. Code: (AsPL5) |  
|--------------------------|---
| The planning process for the attention and care of each patient in imaging includes implementation, taking and monitoring of exams and procedures for the achievement of results to users and/or clinical practitioners. | 5 4 3 2 1 |

Criteria:

- Mechanisms for timely communication of results are guaranteed.
- Mechanisms are in place to ensure the correlation between test results and procedures and decisions of a clinical nature.
- Alarm mechanisms are in place in the event of critical results.

| Standard 27. Code: (AsPL6) |  
|--------------------------|---
| The planning process of attention and care of each patient at a clinical laboratory includes implementation, taking and monitoring of exams and procedures for the achievement of results to users and/or clinical practitioners. | 5 4 3 2 1 |

Criteria:

- In the clinical laboratory, it is ensured that the processes for taking of samples are based on evidence and are reviewed and adjusted periodically, based on new evidence.
- Mechanisms for timely communication of results are guaranteed.
- Mechanisms are in place to ensure the correlation between test results and procedures and decisions of a clinical nature.
- Alarm mechanisms are in place in the event of critical results.

| Standard 28. Code: (AsPL7) |  
|--------------------------|---
| The key points of care and treatment for specific care processes are standardized within the organization, which support the appropriateness and effectiveness of interventions. | 5 4 3 2 1 |

Criteria:

- The place and services required to achieve the objectives with the patient are identified.
- Planning for emergency childbirth and newborn care (specific criteria for maternal and child services)
- Planning of special care, such as caesarean sections, induced labor and instrumental delivery (specific criteria for maternal and child services)
- Counseling in cases of spontaneous abortions, preterm labor delivery, stillbirths, fetal deaths and resuscitation procedures in neonates (specific criteria for maternal and child services)
- Coordination of care between services to identify and intervene promptly to high-risk maternal and child
- Emotional support to the user and family in relation to the impact of surgery experience, ethical issues as brain death, withdrawal of life support systems, non-treatment decisions and no resuscitation. This criterion applies only when the circumstances mentioned above are already present or put in place (specific criteria for surgery service or critical care units).
- Rehabilitation according to physical, occupational, recreational and communication needs (speech and hearing), if applicable
- Nutritional assessment at inpatient and recording the orderly diet
- Special nutritional support
- User tastes and preferences regarding diet are analyzed and alternatives offered.
- Admission and discharge to intensive care unit
- Interdisciplinary approach of complex cases
- Criteria for timely and effective response to inter-consultations
- Recreational activities for infants and adolescents are provided and special activities for elderly users.
- Counseling and emotional support to the user and family, according to the progress and response to treatment, preparation for the physical, social and emotional consequences of the disease, including death and organ donation, when applicable.
- Spiritual or religious support

Continued
Continued

- If the patient will undergo a surgical intervention, pre-anesthesia evaluation is performed, providing the patient with all relevant and sufficient information on risks, preparation, consequences, procedures, etc.
- If the organization operates during evening hours, it should clearly specify the services it can provide and those it does not. In any case, it has a patient referral system for referring what is explicitly defined as out of reach for resolution at this hour.
- The personnel necessary is guaranteed to provide timely care to the expected quality level in both daytime and night, weekends and holidays.
- There is a process to inform the caregivers involved in the treatment of the role to be played.
- Patient and family involvement is encouraged in promotion and prevention programs that apply.
- The organization demonstrates the availability and effectiveness of the care described in this standard.
- Understanding by the user of the information provided in this standard is verified.
- Corrective measures are taken when deviations are discovered.

**Standard 29. Code: (AsPL8)**

The organization plans, disseminates and evaluates health promotion and disease prevention programs in line with the most significant public health problems of the population it serves. The monitoring results show the impact on the user population. Programs include, when applicable, but are not limited to:

<table>
<thead>
<tr>
<th>Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sexual and reproductive health</td>
</tr>
<tr>
<td>• Growth and development</td>
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<tr>
<td>• Nutrition and food programs</td>
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<tr>
<td>• Visual Health</td>
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<tr>
<td>• Oral health</td>
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<tr>
<td>• Chronic and degenerative diseases</td>
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<tr>
<td>• Mental Health</td>
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<tr>
<td>• Vector-borne Diseases</td>
</tr>
<tr>
<td>• Prevention of infectious diseases (acute diarrheal disease and respiratory infections, etc.)</td>
</tr>
</tbody>
</table>

**Standard 30. Code: (AsPL9)**

The organization ensures that the patient and family are informed about the conditions related to their disease or health condition and that the patient is trained to develop skills in self-care of his or her health during the care process.

<table>
<thead>
<tr>
<th>Criteria:</th>
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</thead>
<tbody>
<tr>
<td>• Based on an assessment of needs for disease prevention and health promotion, the patient is informed of joint efforts for the management of the disease and, together with the user, a plan is prepared for related activities.</td>
</tr>
<tr>
<td>• The organization ensures that information interventions and skills development are documented, implemented and evaluated, including evaluation of the results obtained in relation to expected outcomes.</td>
</tr>
<tr>
<td>• The organization ensures that data on the needs and the plan on health promotion and disease prevention are delivered to all organizations responsible for the health of the user and, where relevant, to national or local entities, to set up the clinical quality or epidemiological data bases.</td>
</tr>
<tr>
<td>• The organization ensures that patient medical records have user information on disease prevention and health promotion.</td>
</tr>
<tr>
<td>• The organization ensures that users, relatives, staff and visitors have access to information about disease prevention strategies and activities to promote health.</td>
</tr>
<tr>
<td>• There is a record of extramural activities that meet the criteria of the standard.</td>
</tr>
<tr>
<td>• Corrective measures are taken when deviations are discovered.</td>
</tr>
</tbody>
</table>
Standard 31. Code: (AsPL10)

The organization’s process for achieving and verifying the understanding of informed consent is clearly defined. When requesting consent, the patient will be provided with information about the risks and benefits of planned procedures and risks of no treatment so they can make informed decisions.

Criteria:

- A special consent by the patient is obtained if he or she is to be part or is asked to participate in a research project the purpose, benefits and drawbacks of which have been explained to the patient. Refusal by the patient may not be barrier to medical care appropriate to the condition, but patient autonomy should prevail.
- A record signed by the patient is obtained when the patient consciously chooses not to undergo the procedure suggested by the treating team or professional.
- Informed consent should include at least the benefits, risks and alternatives, according to the specific procedure.
- Professionals responsible for informed consent undergo training and are evaluated for:
  - Adequacy of information content
  - Communication and dialogue skills
  - In cases of reoperation, informed consent is updated
  - Adequate, timely and accurate processing of the informed consent is evaluated.
- Treating professionals are trained about their responsibility for proper communication on informed consent and for checking understanding by the patient.

Standard 32. Code: (AsPL11)

In the process of care planning, the organization should have a policy of humane care as a fundamental element of respect for the user, his or her privacy and dignity:

Criteria:

- Users are tested and have the opportunity to ask questions in privacy conditions.
- Privacy is respected as the user bathes, undresses or while is cared by a professional or technician. (Including trainees)
- Privacy should be visual and auditory.
- All forms of discrimination are studied, intervened and prevented.
- The organization ensures that there is a confidentiality policy regarding user information and that his or her presence in the organization will not be disclosed without consent.
- In support diagnostic services and therapeutic supplementation, it should be ensured that patient privacy is maintained during sampling, conducting the examination and delivery of results. Users are provided, where they so warrant, the physical elements (dresses, gowns, jars, tubes etc.) to ensure the privacy and dignity during sampling or testing.
- Procedures for defining visiting hours, consulting user needs and preferences, with priority to children, elderly, obstetric and adult patients in critical condition
- Considerations in tastes and preferences of patients in their diet, presentation of food, schedules, etc.
- Special considerations for accompanying the dying patient and support for a good death
- Development of communication and dialogue skills to all staff, including consideration when conveying painful information to the patient and family
- Procedures for the respectful and considerate management of the information given to the media about patients
- Humanization in the process of prescribing and administering medications, performing procedures and sampling: hours articulated with relaxation times of the patients, ways of administration to consider comfort and pain level.
- Comprehensive approach to pain management
- Respect of special conditions of vulnerable communities
- Respect to the body and emotional support to families
- Policies to reduce visual and noise pollution. Promote quiet conditions.
- Inclusion of humanizing elements in the physical environment of care (comfort, signage, information, etc.)
- The respectful approach of traditions, beliefs and values of users
- Location and technological conditions that promote timely care, reducing delays and making lines, etc.
- Developing strategies to promote courteous and respectful care to users and their families
- Development of playful-type care strategies, especially for children and elderly, and to contribute to the proper use of time in prolonged hospitalization (reading, crafts, etc.)
- The development of the activities of this standard is deployed to all staff of the organization, including third parties hired
- Risk management related to the lack of humanization in service
- Corrective measures are taken when deviations are discovered.

**Standard 33. Code: (AsPL12)**

The organization ensures that the treatment plan includes care needs and pharmacological advice for each patient. This involves:

<table>
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<tr>
<th>Criteria:</th>
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<tbody>
<tr>
<td>• Design of a pharmacological treatment plan</td>
</tr>
<tr>
<td>• Implementation of the policy of rational use of antibiotics</td>
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<tr>
<td>• Participation of the interdisciplinary team to define antibiotic if the situation so requires</td>
</tr>
<tr>
<td>• Participation of pharmacy service</td>
</tr>
<tr>
<td>• Participation of infectology if complexity so requires</td>
</tr>
<tr>
<td>• Reconciliation of medications at admission</td>
</tr>
<tr>
<td>• Pharmacovigilance</td>
</tr>
<tr>
<td>• Alarm signals and mechanisms for separating medicines with similar name or aspect, to prevent administration errors</td>
</tr>
<tr>
<td>• Review of all orders in that department before delivery of drugs</td>
</tr>
<tr>
<td>• Mechanisms to timely notify the health team about specific patient medication needs (criterion does not apply to outpatient services). These drugs refer to those that the patient normally consumes as a therapeutic scheme for diseases or conditions different from the current cause for care. The health team must take special care to incorporate these drugs in the treatment plan and record them in the patient’s records.</td>
</tr>
<tr>
<td>• Mechanisms to provide information to the user or family about drugs that are to be used. Special attention is paid for the use of those drugs the collateral or side effects of which are dangerous or severe, in order to identify early signs and symptoms of these effects.</td>
</tr>
<tr>
<td>• Mechanism to study, justify, request and dispense drugs not included in the Mandatory Health Plan</td>
</tr>
<tr>
<td>• Corrective measures are taken when deviations are discovered.</td>
</tr>
</tbody>
</table>

**Standard 34. Code: (AsPL13)**

The organization has a methodology defined for diagnostic investigation that seeks to optimize the treatment. The above includes analysis and diagnostic assessments that serve as baselines to monitor the patient’s response to prescribed treatments if the disease or clinical condition warrants it.

<table>
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<tr>
<th>Criteria:</th>
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<tbody>
<tr>
<td>• Planning information and diagnostic research is discussed among members of the health team and is promptly informed to the user and family. The information provided should be written in the medical record.</td>
</tr>
<tr>
<td>• There is a defined process for referral of orders of diagnostic needs, either within the organization or different, and it includes:</td>
</tr>
<tr>
<td>• A set of rules that determine how diagnostic tests are requested, how they are taken, identified, stored, the samples transported and how results are reported.</td>
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<tr>
<td>• Orders for diagnostic tests include relevant clinical information.</td>
</tr>
<tr>
<td>• The user is instructed about the preparation for taking exams.</td>
</tr>
<tr>
<td>• To ensure safe care, the results include an interpretation, legibly, signature, stamp, code of person responsible and results date.</td>
</tr>
<tr>
<td>• Information is provided to users and relatives about the results of the tests or diagnostic procedures. Special attention is given to the information provided to the family in the case of minor patients, disabled or in a state of unconsciousness.</td>
</tr>
<tr>
<td>• The organization ensures a process that identifies and designates persons authorized to request diagnostic tests.</td>
</tr>
<tr>
<td>• Corrective measures are taken when deviations are discovered.</td>
</tr>
</tbody>
</table>
Standard 35. Code: (AsPL14)
The clinical laboratory, when the organization takes the sample to be referred to an intra or inter-institutional laboratory, should have processes based on best practices, to ensure the security, conservation, quality, reliability and confidentiality of the same, according to the clinical condition of the user.

Criteria:

- Personnel taking or transporting samples is trained and is subject to monitoring of adherence to established procedures.
- The organization has standardized and controlled transfer times and conditions.
- Corrective measures are taken when deviations are discovered.

Standard 36. Code: (AsPL15)
The organization ensures that in the clinical laboratory, pathology and imaging are assigned and know the process owners and have protocols that define explicit criteria for:

Criteria:

- Competencies of the staff responsible for the care and mechanisms for evaluation
- Marking of elements
- Minimum clinical information to be contained in applications of tests (including those which are urgent or made at night) and reports
- Registration of orders that do not meet the above criteria; this information is shared and discussed with professionals who refer or request tests, including a system of advice for proper filling out of orders
- Verification of the identity of the user that is checked against the medical order and the marking of the products used in procedures
- Control of sample transfer times
- Measurement of the timeliness of reporting
- Acceptance or rejection of samples or images. If compromised samples or doubtful images are accepted, the final report should indicate the nature of the problem and caution in interpreting the results. This includes:
  - Analysis to identify the causes that led to the damage of the sample or image
  - Information to the user for retaking of the sample or image
  - This information should be part of the Patient Safety program.
- Corrective measures are taken when deviations are discovered.

Standard 37. Code: (AsPL16)
The organization has standardized reporting mechanisms and delivery of diagnostic test results (clinical laboratory, pathology, images) that ensure reliability and confidentiality in the handling of information. This includes:

Criteria:

- Duration of the processing and delivery of results. If for some reason the results are going to take longer than expected, there is a system to alert the professional and/or user of such delay. The explanation must contain accurate information of when the result will be ready. Additionally, the causes that led to the delay will be analyzed and action will be taken.
- For these cases, it will generate a process of classification and ordering of tests and procedures requested, based on prioritization criteria, in order to evacuate them in order of priority.
- The delivery of all results of examinations and procedures in writing. In exceptional cases, when delivery is made to the health team by telephone, a record of who gives and who receives will be carried. In no case can the result be delivered verbally to the user.
Continued

- Process for storage and preservation of the original report, even though the written result is a transcript or recording and it is not performed by the person who carried out the analysis of the tests.
- Systematic and periodic audit process to identify consistency and traceability between different records.
- Delivery of all reports to the user or physician is guaranteed, as defined in the process, with specific guidelines for delivering those results that may affect the integrity of individuals (e.g. cancer, HIV, any abuse, procedures that are part of a legal process, etc.).
- A process to evaluate the correlation between the clinic and the results of examinations performed.
- The permanent advice to professionals who need it to correctly interpret the results.
- Procedures for identifying and evaluating errors in delivering results. In these cases, an immediate response must be generated to stakeholders and the anomaly must be recorded.
- Error analysis in any phase of delivering results for corrective action.
- Corrective measures are taken when deviations are discovered.
- This information should be part of patient safety program.

**Standard 38. Code: (AsPL17)**
The laboratory has a recognized and proven internal and external quality control program.

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**Criteria:**

- Registration is carried of quality control actions and corrective actions established by the organization, which are known and analyzed.
- An updated calibrations log is made for each quantitative test in the laboratory, indicating date and results of the controls obtained.
- The laboratory has a system to compare the results of external quality control of proficiency testing against valid performance standards for all tests performed in the laboratory.
- The laboratory should periodically verify the validity of the analysis interval of the methods used.
- A record of the dates and results should be kept.
- In the microbiology section, the laboratory should keep records of monitoring of the culture media, stains and sensitivity by ATCC organisms
- In the hematology section, the laboratory must process daily at least three levels of quality control and must carry a corresponding record. In the coagulation section, the number of control levels must be at least two.
- Records referred to in the above criterion must be kept.
- In the immunology section, the laboratory must perform verification of the procedure by processing controls (positive and negative) each time the tests are performed.
- The laboratory must keep records of actions when the results of external quality control do not meet the acceptable limits. Chemistry, two levels; immunoassays, least three levels.
- Corrective measures are taken when deviations are discovered.

**Standard 39. Code: (AsPL18)**
The organization has standardized processes to ensure the prevention and control of infections during user care. Processes are based on guidelines or protocols including:

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</table>

**Criteria:**

- Admission and intra and inter-institutional transport of infected patients
- Standardization, implementation and monitoring of adherence to isolation techniques
- Guarantee of the use of aseptic techniques for the preparation of intravenous medication, chemotherapy, or parenteral nutrition
- Antibiotic prophylaxis
- Rational use of antibiotics
- Using antibacterial resistance profile
- Disinfection protocols
- Surface culture reports
- Actions of the epidemiological surveillance committee
- Actions in the event of outbreaks

Continued
- Adjustment of clinical practice guidelines based on the bacterial resistance profile
- Collection, tabulation, analysis and reporting process of nosocomial infections and communicable and infectious diseases:
  - Definition of infections associated with health care
  - Defining mechanisms for reporting and research protocols in cases of nosocomial infection
  - Implementation, measurement and management of indicators of infection according to complexity and by service. At a minimum, reference crediting indicators, e.g. central catheter-associated infection, surgical site infection, postpartum endometritis, ventilator-associated pneumonia, urinary catheter-associated infection
- Report the results to management or other relevant groups within the organization
- The plan for prevention and infection control is incorporated into the plan of strategic direction of the organization.
- The plan for prevention and control of infections has specific goals that are measured in time.
- Responsibility for infection prevention is identified.
- The staff of the organization receives orientation, re-orientation and training in the prevention and control of infections.
- Ventilation system for pollutants, if applicable.
- Sterilization according to the needs of services.

<table>
<thead>
<tr>
<th>PERFORMANCE OF TREATMENT</th>
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<tbody>
<tr>
<td><strong>Standard 40. Code: (AsEJ1)</strong></td>
</tr>
<tr>
<td>A plan of care and treatment is in place that comprehensively incorporates risk analysis and needs of the patient and family through proper articulation of the interdisciplinary team required for this purpose.</td>
</tr>
<tr>
<td>Criteria:</td>
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<tr>
<td>- The organization ensures that the treatment is performed by a trained interdisciplinary health team, with the technical and scientific capacity to fulfill this role in a team. Staff is adequate to perform the treatment according to complexity.</td>
</tr>
<tr>
<td>- Consultations are performed in a timely manner and the effectiveness thereof is evaluated.</td>
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<tr>
<td>- The organization promotes and evaluates teamwork and interaction of the people responsible for treatment.</td>
</tr>
<tr>
<td>- Nutritional assessment is performed.</td>
</tr>
<tr>
<td>- All major risks to patients are taken into account.</td>
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<tr>
<td>- The organization ensures that the treating professional provides basic information to the user and family as a result of the attention.</td>
</tr>
<tr>
<td>- Corrective measures are taken when deviations are discovered.</td>
</tr>
</tbody>
</table>

| **Standard 41. Code: (AsEJ2)** |
| The user and family receive education and relevant information during execution of the treatment, which includes at least: |
| Criteria: |
| - Natural development of the disease and the present state of it: |
|  - Excellent understanding and acceptance by the user of the treatment and its objectives. |
|  - The therapy and medications prescribed, schedules and interactions. Special attention is given for the use of drugs the collateral or side effects of which are dangerous or severe, to identify early signs and symptoms of adverse drug reactions. |
|  - Necessary and sufficient information on test results or diagnostic procedures, ensuring proper understanding by the user and/or family, especially in the case of minor patients, or with some degree of physical and/or mental disability. |
|  - Specialized caregiving and counseling on information of results in cases of patients with catastrophic diseases, especially cancer, STDs, HIV or AIDS: |
|   - Care to be provided at the time of hospitalization and needs after discharge (home care, if applicable). |
|   - Health promotion and disease prevention, including participation in preventing infections. |
|   - Active participation of the user in promoting his or her own safety. |
|   - The organization assesses the understanding by users of all information and education received during the care process. |
|   - Corrective measures are taken when deviations are discovered. |
**Standard 42. Code: (AsEJ3)**

The care and treatment are consistent with standards of practice based on the best available evidence.

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</table>

Criteria:
- The organization has a periodic internal evaluation of a sample of medical records by peers for purposes of monitoring and improving processes of care or clinical practice guidelines.
- The organization has mechanisms to ensure that the processes of care or health care to their patients (as well as the management of adverse events) are subject to the clinical practice guidelines and/or guidelines for conducting previously defined diagnostic procedures.
- The audit for quality improvement evaluates that the care and treatment are consistent with the guidelines, it measure adherence, provides feedback and promotes improvement measures.
- Availability, ease of query, update and use of guidelines and coverage thereof are evaluated.
- Patient care is carried out in a multidisciplinary manner, which is consistent with the clinical practice guidelines of the organization.
- Adherence to the plan of care and treatment is evaluated.

**Standard 43. Code: (AsEJ4)**

The organization has a specific process standardized for identifying victims of child abuse, sexual abuse or domestic violence. It defines and adopts criteria for approach and initial treatment, notifying relevant authorities and/or agencies, monitoring and psychological and spiritual counseling (respecting their religious beliefs).

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Criteria:
- The organization adopts the chain of custody guideline established by the competent authority, as applicable, including security and preservation of legal evidence.
- The organization has strategies documented for detection and intervention of these cases of violence and monitors adherence to application.
- The organization has a protocol for reporting such events, including the record of the report in the medical record.
- The professionals have been trained to detect cases of child abuse, sexual abuse and domestic violence.
- Corrective measures are taken when deviations are discovered.

**Standard 44. Code: (AsEJ5)**

The organization has standardized processes to ensure that during the execution of the treatment the user has the right, if the user so requests or requires, to a qualified second opinion of his or her medical condition. This right must be informed through any mechanism in the organization, including the same treating professional.

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Criteria:
- The treating practitioner must be informed of this right.
- The organization must respect this right and in no case may refuse or limit user access if he or she decides to consult again.
- The organization has mechanisms to analyze, in an interdisciplinary way, when the condition warrants, complex or complicated cases and provide management alternatives.
- The implementation of treatment addresses strategies for the humanization of care.

**Standard 45. Code: (AsEJ6)**

The organization has standardized health education strategies for users which meet the needs of the target population.

Continued
Criteria:
- The parameters used to define the needs of health education must be provided in the content of the care guidelines.
- The process has clearly defined goals and objectives, with an evaluation system (including indicators of user satisfaction) and a proactive information or marketing system to potential users.
- The programs are supported with educational materials to facilitate the fulfillment of the objective.
- Where there are specific education groups different from the treating health team, there must be a defined feedback mechanism to the treating healthcare group. The above should be recorded in the patient record.
- The user education includes participation in safety during the care process.

### EVALUATION OF CARE

#### Standard 46. Code: (AsEV1)

The organization guarantees that it reviews the individual plan of care and outcomes grounded on medical history and health care records in a systematic and regular basis, which allows qualifying the effectiveness, safety, timeliness and validity of care through the information provided and to adjust and improve processes.

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</thead>
</table>

Criteria:
- The organization has a periodic internal evaluation system of a sample of medical records and/or care records by peers, for cases of adverse events.
- It has a mechanism to provide feedback to the health team on the results of the evaluation of their medical records and/or care records.
- The organization has a mechanism to assess adherence to treatment for acute patients and for those enrolled in chronic disease programs. It also has a system for evaluating the causes of non-adherence and it proposes, implements and evaluates the results.
- The organization evaluates its clinical results and compares them to national and international benchmarks.

#### Standard 47. Code: (AsEV2)

The organization has a standardized process that systematically and periodically monitors user feedback and suggestions, personal requests, compliments and complaints of users and has a mechanism to respond in a timely and effective manner and provide feedback to the staff of the institution on behavior or tendency of the process and the implemented intervention for improvement. It includes:

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</thead>
</table>

Criteria:
- Consolidation, analysis and formulation and implementation of improvement actions
- Knowledge of the process by all those who have direct contact with the public
- Training on the changes and improvements made
- Indicators of timeliness and effectiveness of responses.

#### Standard 48. Code: (AsEV3)

The organization has an internal definition of what constitutes a chronic querier for a given service, and has processes established to quantify and generate action to assess and monitor the situation.

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</table>

Criteria:
- The organization ensures that the caregivers know the definition and the process mentioned in the standard.
- The personnel involved in the process apply it according to the definition by the organization.
- The assessment of the adequacy of service utilization is based on explicit criteria and prioritizing patient safety.
Standard 49. Code: (AsEV4)
The organization providing dental services ensures that they are developed in a systematic and permanent manner, with mechanisms for evaluating the effectiveness and continuity of patient care process in oral health, taking into account inter alia the following criteria:

Criteria:

- Portfolio of services of the institution
- Detection of needs and expectations of the user and family
- Mechanisms to measure adherence to the treatment plan
- Indicators of effectiveness and timeliness

**DISCHARGE AND MONITORING**

Standard 50. Code: (AsSAL1)
The organization has a standard process for discharge of patients, which guarantees the user and family the proper completion of care and monitoring process. It includes:

Criteria:

- Strategies to identify needs and plan a continuum of patient care after discharge
- It has time standards established for processes related to patient discharge, including billing of services.
- For cases in which the clinical, physical and/or mental condition warrants, discharge will be given in the company of a responsible adult prior evaluation by the treating physician.
- Communication of all relevant information to the health promoter, manager, or similar, for the authorization and planning of comprehensiveness and ongoing monitoring
- Documented and referral plans for monitoring and treatment that include: location, date and referral reasons and who to contact, if applicable
- Report of the outcomes of care and treatment, if applicable. This criterion does not apply to outpatient services.
- There is a document containing the final report of stay and future requirements needed for every patient who is discharged from the organization. This criterion does not apply to outpatient services.
- Information on the procedures that users must perform if they need a referral or request an appointment with another provider. This process may be made by the treating physician or other staff of the organization that has been officially delegated to do such work. This does not imply the existence of a service or functional unit.
- Written care plan that includes the explanation commensurate with the level of knowledge and understanding of the patient and family about the care to be followed once the patient is discharged, including information about drugs and their administration, use of medical equipment, food and rehabilitation and signs and symptoms of early warning of possible complications, if applicable
- The treating practitioner must provide basic information to the user and family as a result of the care. Special importance is given to the care and self-care at home (special diets, drug monitoring, exercise, rehabilitation, etc.).
- Corrective measures are taken when deviations are discovered.

Standard 51. Code: (AsSAL2)
The organization ensures a coordinating plan with other relevant organizations and communities in preventing disease and promoting, protecting and improving the health of the population it serves.

Criteria:

- The organization ensures that policies, guidelines, processes and procedures for disease prevention and health promotion are aligned with national and local public health standards.
- The organization ensures the existence and implementation of guidelines and/or procedures for monitoring of disease prevention and health after patient is discharged.
**REFERRAL AND COUNTER-REFERRAL**

**Standard 52. Code: (AsREF1)**

If it is necessary to refer clients between services or between institutions, the following processes should be ensured:

1. The organization has explicit guidelines and criteria on the type of cases to be referred, when they are referred, why they are referred and to where they will be referred, among others.
2. The organization ensures that all referrals have the relevant clinical patient information.
3. It provides clear and complete information to the user and family about the referral process and administrative procedures to follow in order to receive the service at the place where the user has been referred.
4. The organization ensures that professionals that refer their users have feedback on the outcome of care and that this information is incorporated into the patient medical records.
5. Clinical relevance and efficiency of administrative procedures of referrals is evaluated. Corrective measures are taken when deviations are found.

**Standard 53. Code: (AsREF2)**

For referrals to specific services, as applicable, the following additional criteria will be considered:

**Criteria:**

REFERRAL TO LABORATORY OR DIAGNOSTIC IMAGING

- There is a set of rules that determine how and what information is needed to order diagnostic tests and who has privileges to request such reviews.
- The patient is instructed about the preparation for taking exams, if the condition warrants it. This indication should not replace the information the patient should be provided by the appointment assigning process.
- The user is informed of the availability for the timely taking of tests and the procedures for requesting the appointment.
- The organization must first determine whether the results are delivered to the user and/or the professional who requested the test directly. In either case, the person must be informed when the results of the test will be ready and what the mechanism for collection or delivery is.
- After obtaining the test results it should be ensured that:
  - There should always be a record in the patient’s medical history of the results and behaviors followed by the treating professional.
  - Information is provided to users and family about the results of the tests or diagnostic procedures. Special attention is given to the information provided to the family in the case of minor patients or mentally disabled.
  - The organization may define, taking into account specific situations, if delivery and if the feedback on the results of the tests warrants the physical presence of the patient in a follow-up appointment.
  - There must be some later monitoring mechanism for user to understand the information given by the professional.
  - The organization has mechanisms for communication with providers of laboratory or images services, when the results do not include reading or are in illegible handwriting, without signature or seal, without the code of the responsible person and undated results. It should also be ensured that an advice and counseling mechanism exists between the two services in the interpretation of results.
  - Alarm mechanisms are applied for critical results and measures developed for urgent and confidential notification to the treating professional, institution and those responsible for the specific programs, if applicable.

REFERRAL TO EMERGENCIES

- Prior to the transfer, it must be ensured that the receiving organization has availability of service.
- In the transfer process, there must be minimum information that includes: who transports, how it is transported, why it is transported, where it is transported and who receives in the receiving organization. This criterion does not replace the criterion that requests that in all cases the patient be accompanied by the relevant clinical information.
- The appropriateness of referrals is assessed and corrective measures are taken when deviations are found.

*Continued*
Continued

REFERRAL TO DRUG PROVISION SERVICES
- It guides the user on where and at what times the drugs are supplied.
- The organization has mechanisms to verify the completeness and timeliness of delivery of drugs to users. This does not imply that the sending organization is directly responsible for the delivery of drugs; it only verifies the quality criteria above.

REFERRAL TO DIFFERENT COMPLEXITY OUTPATIENT SERVICE
- The professionals explain to the user the relevance of why it is necessary to have a specialized opinion in his or her process of care and treatment.
- Information on how to request the appointment and administrative procedures to be performed is provided.
- There are coordinated actions between services and institutions for establishing opportunity parameters.

REFERRAL TO HOSPITALIZATION
- If the patient is referred directly to hospitalization, coordination of this process should be ensured from the care center.
- There are records of who coordinates the process, who will receive the patient, where they will receive him or her and the availability of a hospital bed, as well as evidence of compliance with the conditions for continuity of care.
- The organization ensures that the user was attended by the organization to which user was referred.

REFERRAL TO PROMOTION AND PREVENTION PROGRAMS
- The organization should have processes and explicit criteria, known by the staff of the organization, preferably supported on information systems (alarm systems, reminders, etc.) to refer patients to special promotion and prevention programs. The sender, a professional, must know if care was provided or not.

INFORMATION TO THE SENDER ORGANIZATION OR PHYSICIAN
- When the organization is the recipient of a referral patient, the physician or organization that referred the patient is informed about the referral user’s care.
- The referral order of the professional must contain a summary of the clinical condition of the patient and of indications.
- If the professional has any questions or suggestions about the requested services, the organization has standardized communication mechanisms and agreement among the senders, professionals, always noting the consensus achieved.

Standard 54. Code: (AsREF3)
If the laboratory professional or leadership needs to refer a sample of a user from the network to a laboratory of different complexity, of the same service network or to a different organization, the following processes must be ensured:

<table>
<thead>
<tr>
<th>Criteria:</th>
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</thead>
<tbody>
<tr>
<td>• The organization has protocols and explicit criteria for cases that are referred: referral purposes, dates, locations, user information, when and where to refer, among others. These protocols are supported by the existence of the necessary documentation to support this process.</td>
</tr>
<tr>
<td>• The organization ensures that referrals to laboratories of different complexity have relevant clinical patient information.</td>
</tr>
<tr>
<td>• It provides clear and complete information to the user or family on administrative procedures to be followed to obtain the service that relates to the samples.</td>
</tr>
<tr>
<td>• There is a protocol for pre-shipment maintenance and conservation of samples.</td>
</tr>
<tr>
<td>• There is a process that ensures the safety of the samples that have been referred and that there is no confusion regarding the sample and identity.</td>
</tr>
<tr>
<td>• There is a protocol for receiving samples transported and statistics are carried of second samples for preanalytical problems.</td>
</tr>
</tbody>
</table>

Standard 55. Code: (AsREF4)
In imaging, there is a process or mechanism, upon discharge of the user care process, to report on the procedures to be performed if a referral is needed or an appointment requested with another provider. This process may be done by the treating physician or another staff of the organization that has been officially delegated to perform this task. This does not imply the existence of a service or functional unit to perform such work.
Standard 56. Code: (AsREF5)
In habilitation and rehabilitation service, there is a mechanism, upon discharge of the user care process, to inform the patient about the procedures that must be performed if a referral is needed or appointment requested with another provider.

Standard 57. Code: (AsREF6)
The organization has time standards established for processes related to the discharge of the patient, including billing of services. Periodic monitoring of compliance with these standards and design, implementation and evaluation of corrective mechanisms is warranted when a poor performance pattern is observed against the established standard.

NETWORK INTEGRATED OFFICES

Standard 58. Code: (AsSIR1)
There is an explicit definition of the reasons for forming the network and the design is based on providing ease of care to the patient and family.

Standard 59. Code: (AsSIR2)
If the provision network has an explicit differentiation of services per provider, this information must be clear for the user and for the appointment allocation process.

Standard 60. Code: (AsSIR3)
For the former case, the network management ensures that it has processes designed and implemented to identify referral and counter-referral mechanisms between the different service providers, which ensure coordination and continuity of user care.

Standard 61. Code: (AsSIR4)
The network has a centralized monitoring process of the quality of medical records and clinical results, including analysis of adverse events. This does not exclude the participation of staff working in each of the organizations that are part of the network. Corrective measures are taken against the detected deviations.

Standard 62. Code: (AsSIR5)
There is a process of a single central strategic direction for the network, shared by all, which includes a clear description of what the role of each provider in the network is in achieving common purposes. There are operational plans of the processes and they include the contribution of the offices to the general strategic direction. Operational plans include goals and indicators to evaluate the management of each office. Corrective measures are taken against the detected deviations.

Standard 63. Code: (AsSIR6)
The strategic direction, with its objectives and strategies, establishes how the synergy and coordination around the patient between different providers is generated. The management of the network has mechanisms to demonstrate the results of this synergy. The information system should provide data for the evaluation of these mechanisms.
### Standard 64. Code: (AsSIR7)

Information systems in the network must ensure that they have a unified database of records and care of patients, which can be accessed by each of the different providers at the place where care is given to the patients.

### Standard 65. Code: (AsSIR8)

When there are several offices and the user can consult several of them, there must be a system for sharing medical records and then consolidate them after each patient visit, regardless of whether the information is in magnetic form or physical (paper).

**Criteria:**
- The user can request the appointment in the Health Care Institution of his or her choice.

### Standard 66. Code: (AsSIR9)

Records that are used in the processes of patient care should be standardized, including acronyms to be used in both the medical and administrative part. Records must ensure completeness, regardless of where the patient is received and served and should facilitate the coordination and continuity of care of the patient.

### Standard 67. Code: (AsSIR10)

Regardless of the information generated and stored in each provider in the network, the network management collects, processes and analyzes information from its providers at the central level. The analyses should be possible to disaggregate from the overall performance of the network to the individual performance of each provider.

### Standard 68. Code: (AsSIR11)

The network management ensures, for those cases where the patient is perceived with a holistic approach to care by various providers in the network, that in each of these services, the health status of the patient is evaluated and this information is recorded in clinical records.

### Standard 69. Code: (AsSIR12)

The network management ensures that each of providers that comprises the network receives detailed and timely information about the services, programs, guidelines, policies, etc., that are formulated from this management.

### Standard 70. Code: (AsSIR13)

The network management must articulate clinical support technologies (e.g. lab) and administrative support technologies (e.g. billing systems) and avoid duplication of information or unnecessary waste of resources.

### Standard 71. Code: (AsSIR14)

The network management ensures that each of the providers in the network has physical environment conditions in accordance with planned developments, organizational policies and accreditation requirements.

### Standard 72. Code: (AsSIR15)

The management of the network has mechanisms for planning and operationalization of programs that identify the best assessment of costs and benefits in the use of technology among different providers that are part of the network, reflecting the degree of complexity of the providers.
Standard 73. Code: (AsSIR16)

There is a medium-term plan for submission to accreditation of all networking integrated offices. In case of gradual inception, the time of the entire process must be made clear and it must include first the headquarters and offices where the largest number of users is served.

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**STANDARD OF IMPROVEMENT**

Standard 74. Code: (AsMCC1)

Management of improvement opportunities considered in the organizational continuous improvement process, which apply to the group of standards, is developed taking into account:

| 5 | 4 | 3 | 2 | 1 |

Criteria:

- The organizational approach to continuous improvement
- The implementation of prioritized improvement opportunities and removing the barriers to improvement by self-assessment teams, improvement teams and other associates in the organization
- The articulation of opportunities for improvement that relate to the different processes and groups of standards
- The monitoring of the results of improvement, verification of cycle closing and quality maintenance and assurance
- Communication of results
7.2 GROUP OF DIRECTING STANDARDS

Standards 75 to 87

INTENTION OF THE GROUP OF DIRECTING STANDARDS (DIR)

The expected outcome when an institution obtains compliance with the standards of this group is:

- That the organization is aligned with the strategic direction for the achievement of expected institutional results in a management approach focused on the customer and continuous quality improvement. To this end, the organization has processes for:
  - Reading of the environment
  - Formulation and periodic review of strategic direction
  - Building of a strategic direction plan
  - Communication, dissemination and orientation of staff
  - Justification of staff management to the board
  - Monitoring and evaluation of the strategic direction and the strategic plan
  - Comprehensive assessment of health management

This includes:
- The emphasis in the following areas: customer-focused management and continuous improvement, patient safety, humanization of care, management of technology, risk approach aimed both at long-term cultural transformation and social responsibility.
It is expected that the organization comply with the incorporation of relevant regulations, ethical aspects, the needs of the user and family, the needs of workers, the relationship with the community it serves and the interaction with other organizations in developing a healthy environment.

- The incorporation of relevant regulations, ethical aspects, the needs of the user and family, the needs of workers, the relationship with the community it serves and the interaction with other organizations in the development of a healthy environment.
- The policy to promote, protect and improve the health of the population in the area of services it provides and in collaboration with relevant organizations and communities.
- The articulation of strategic direction of the processes of the functional units.
- Continuing education of the board of directors.
- The financial feasibility of implementation of the plans.
- The central strategic direction where there are offices organized in the network.
- The interdisciplinary build of the self-assessment teams for accreditation standards.
- The sustainability of the culture of quality, continuous improvement and maintenance of the entry requirements for accreditation set by the accreditation body.
## Standards of Directing

### Standard 75. Code: (DIR1)

There is a regular and systematic process to define and redefine the strategic direction of the organization, which must include among others the following Criteria:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>• The board, management team and key people in the organization are involved in defining, reviewing and updating the strategic direction.</td>
<td>5</td>
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<tr>
<td>• Ethical and regulatory aspects</td>
<td>4</td>
</tr>
<tr>
<td>• Changes in the environment</td>
<td>3</td>
</tr>
<tr>
<td>• Patient and associate safety</td>
<td>2</td>
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<tr>
<td>• Risk focus and management</td>
<td>1</td>
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<tr>
<td>• Humanization during care provided to user and family</td>
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<tr>
<td>• The planning, development and management of health technology</td>
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<tr>
<td>• Analysis of the aspects of the community (values, beliefs, customs, economic barriers, geographical, social, cultural) to guide the provision of services</td>
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<tr>
<td>• The synergy and coordination between different providers for care to users</td>
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<tr>
<td>• Social responsibility to the user, associates, the community and the environment</td>
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<tr>
<td>• The mission clearly defines the purpose of the organization and its relationship with the community it serves.</td>
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<tr>
<td>• The vision focuses the organization on developing its services.</td>
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<tr>
<td>• The voice of the internal customer and its responsibility to its employees</td>
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<tr>
<td>• The needs of the user and family</td>
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<tr>
<td>• The organization identifies and interacts with key organizations within and outside the sector for cooperation in the development of a healthy environment</td>
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<tr>
<td>• Systematic exercises of comparative and competitive referral that strengthen improvement</td>
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</tbody>
</table>

### Standard 76. Code: (DIR 2)

The organization builds its strategic plan from its strategic direction. Its formulation is standardized, as is disclosure, monitoring and evaluation.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>• The objectives contained in the strategic plan are prioritized, implemented and evaluated.</td>
<td>5</td>
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<tr>
<td>• The organization ensures the participatory formulation of the strategic plan from which operational plans are formulated, consistent with the strategic framework of the organization.</td>
<td>4</td>
</tr>
<tr>
<td>• The strategic and operational plans are approved at the instance concerned.</td>
<td>3</td>
</tr>
<tr>
<td>• Financial, physical resources and human talent have been allocated and approved in the strategic plan for implementation.</td>
<td>2</td>
</tr>
<tr>
<td>• There is a system of distribution, tracking and monitoring of the results of the strategic plan.</td>
<td>1</td>
</tr>
<tr>
<td>• The board evaluates the performance of the strategic plan.</td>
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</tbody>
</table>

### Standard 77. Code: (DIR3)

The organization ensures the deployment and understanding of the direction of the strategic plan at all levels of the organization and stakeholders.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>• Deviations found are evaluated and improvement actions are implemented.</td>
<td>5</td>
</tr>
</tbody>
</table>

### Standard 78. Code: (DIR.4.)

Top management promotes, develops and evaluates the outcomes of actions aimed at user- and family-centered care, continuous improvement, humanization of care, risk focus and management, patient and associate safety, technology management in health, cultural transformation and social responsibility.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Top management promotes, develops and evaluates the outcomes of actions aimed at user- and family-centered care, continuous improvement, humanization of care, risk focus and management, patient and associate safety, technology management in health, cultural transformation and social responsibility.</td>
<td>5</td>
</tr>
</tbody>
</table>
Standard 79. Code: (DIR.5)
The policy of humane care and respect for the patient, patient privacy and dignity is promoted, deployed and evaluated by senior management for all associates of the organization, regardless of the type of connection. Corrective measures are taken when deviations are discovered.

Standard 80. Code: (DIR.6)
The organization has designed, implemented and evaluated a health services provision policy to promote, protect and improve the health of the population it serves, without discrimination. The policy is part of the strategic direction and it is articulated with the institution’s quality policy.

Criteria:
- The service provision policy is aimed at users, relatives and associates.
- The policy reflects the health needs of the type of users or population it serves and promotes the use of evidence and best practice in primary health care and public health, as appropriate.
- The organization ensures that policies, guidelines, processes and procedures for disease prevention and health promotion are aligned with national and local public health standards.
- Its deployment and allocation of resources and responsibilities for implementation, evaluation and revision are defined.
- The staff is familiar with the policy of disease prevention and health promotion and is included in the process of new staff orientation.
- A plan for policy evaluation is ensured, including guidelines for the collection and analysis of data on disease prevention, and health promotion and compliance is verified.
- The necessary competence is assured of care and support staff that is responsible for implementing the policy to carry out disease prevention and health promotion activities.

Standard 81. Code: (DIR7)
There is a process to set the parameters from which the strategic plan and operational plans will be executed. The process ensures the financial viability of the organization through the confirmation of the availability of resources to support the organization’s current and future services and programs.

Standard 82. Code: (DIR8)
There is a process to comprehensively evaluate the organization’s clinical management and delivery model that monitors, based on quality assessment processes in the organization:

Criteria:
- Outcome of the quality information system indicators
- Evaluation of clinical management including adjusted clinical outcomes
- Evaluation of quality attributes and their improvement
- Assessment of the services utilization review: Overuse and underuse
- The approach and outcome of the audit for Quality Improvement in the organization
- Evaluation of risk management
- Corrective measures are taken when deviations are discovered.

Standard 83. Code: (DIR9)
The organization ensures staff orientation, which is aligned with the organization’s strategic direction.
Criteria:

- Development of: Patient Safety, humanization, risk management and technology management
- Orientation and reorientation
- Evaluation of the implementation of strategic direction in the performance of the associate
- Corrective measures are taken when deviations are discovered.

**Standard 84. Code: (DIR10)**

- Consulting and continuing processes and procedures education to the board are in place.

Criteria:

- All members of the board receive, upon entry, orientation on the organization and their functions, and processes of health direction, and on how to conduct successful meetings. This orientation is supported on continuing education in time.
- Continuing education should be in the context of philosophy, policies and processes inherent to the care of clients and their families.
- The when and how directors of functional units advise the board is defined.
- Corrective measures are taken when deviations are discovered.

**Standard 85. Code: (DIR11)**

In institutions with network integrated offices, there is a single central strategic direction process for the network, shared by all, which includes a clear description of the role of each network provider in achieving common achievements. This does not prevent each of the providers from possessing a strategic work plan based on the objectives and goals of the strategic direction of the network mentioned above.

Criteria:

- The strategic direction, in its objectives and strategies, establishes how synergy and coordination are generated around the user between different locations. The management of the network has mechanisms to demonstrate the results of this synergy.
- The information system should provide data for the evaluation of these mechanisms.
- This standard does not relieve each of the different providers that are part of the network from meeting the other standards and sections described in this manual.
- The planning and management of the standard, which should be centralized and headed by a network, does not mean that the institutions that comprise it are not part of the planning, monitoring and improvement of these processes in accordance with the guidelines issued by the network management.
- The standard must be satisfied regardless of whether the physical facilities of the different providers are owned or not by the organization that manages the network.

**Standard 86. Code: (DIR12)**

There is a process to establish the parameters of the teaching-service relationship, aligned with the strategic direction of the organization. This includes:

Criteria:

- Clinician-teaching staff trained in pedagogy
- Teaching experience
- Training and continuing education policies
- Research policies
- Teacher development plan
- Clear definition of roles
- Assignment of responsibilities
- Definition of resources provided by the parties. Skills assessment
- Evaluation of the teaching-service relationship by senior management
**STANDARD OF IMPROVEMENT**

**Standard 87. Code: (DIRMCC1)**

Management of improvement opportunities considered in the organizational process of continuous improvement, which applies to the group of standards, is developed taking into account:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>The organizational approach to continuous improvement</td>
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<tr>
<td>The implementation of prioritized improvement opportunities and removal of barriers to improvement by self-assessment teams, improvement teams and other associates of the organization</td>
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<tr>
<td>The articulation of opportunities for improvement that relate between different processes and groups of standards</td>
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<tr>
<td>Monitoring of the results of improvement, verification of the cycle closing and maintenance and quality assurance</td>
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<tr>
<td>Communication of results</td>
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</table>

-
7.3 GROUP OF MANAGEMENT STANDARDS

Standards 88 to 102

INTENTION OF THE GROUP OF MANAGEMENT STANDARDS (GER)

The expected outcome when an institution complies with the standards of this group is:

- Organizational processes make the strategic guidelines operational, geared towards achievement of expected institutional results, with a focus on customer-focused management and continuous quality improvement. To this end, the organization has the following processes:
  - Identification of the internal and external customers of the process and their needs
  - Definition and monitoring of goals and objectives per functional unit, aligned with institutional goals and objectives
  - Identification and satisfaction of the entry requirements to the accreditation process
  - Assignment of physical and financial resources and human talent to the improvement work
  - The protection of resources
  - If the organization delegates services, the processes to define, agree and monitor the alignment criteria between the delegated service, guidelines and institutional policies and accreditation standards that apply, as well as the improvement of the delegated services
  - This includes strategies and actions of senior management to support with resources
The organization develops a plan to improve the strategic direction processes systematically on the basis of the continuous quality improvement cycle.

and accompany the operating levels in the process improvement activities, a self-control approach of process managers, compliance and respect of patients’ rights and duties

- The organization achieves increasingly better results in institutional or delegated processes regarding expected institutional achievements. To this end, the organization develops a plan to improve strategic direction processes systematically on the basis of the continuous quality improvement cycle. This includes:
  - The definition of a plan with goals and strategies, based on information obtained from the health team, the user and the family
  - The identification of priority care processes and implementing of improvement activities in accordance with priorities
  - The monitoring of process improvement by measuring results
  - The dissemination and deployment of improved outcomes among workers of the institution
  - Identification and effective response to the needs
### Standards Management

#### Standard 88. Code: (GER1)

The organization’s processes identify and respond to the needs and expectations of its internal and external customers and suppliers, in accordance with the objectives of the functional units and it evaluates the effectiveness of response to the processes.

Criteria:

- A methodology to identify and periodically update the needs and expectations of its customers and suppliers
- A group or team to plan and respond to the needs and evaluate the effectiveness of responses
- Description of the customer service process.

#### Standard 89. Code: (GER. 2)

Top management promotes, displays and evaluates that during the process of care, the organization’s associates develop, in the user and family, responsibilities on health self care through training in promotion of health and prevention of disease activities.

#### Standard 90. Code: (GER. 3)

There are organizational policies to define the type, sufficiency, coverage, complexity and scope of services to be provided.

#### Standard 91. Code: (GER. 4)

Senior management has defined and implemented a system of risk management articulated with the strategic direction which:

Criteria:

- Responds to an organizational policy
- Has tools and methodologies to identify, prioritize, evaluate and intervene risks
- Includes the risks related to health care, strategic and administrative risks
- Carries out assessment and improvement actions.

#### Standard 92. Code: (GER. 5)

- Senior management promotes systematic comparison with internal, national and international benchmarks and includes:

Criteria:

- A planned process for referral that prioritizes the practices covered by this referral
- A methodology to identify the best internal and external referrals (benchmarks, indicators, goals, etc.)
- Clinical management processes: adherence to clinical practice guidelines, filling out medical history and diagnostic relevance, etc.
- Evaluation of results adjusted for risk
- Adverse events
- Patient safety, humanization, risk management and technology management
- Improvement actions are implemented from referral processes performed.

#### Standard 93. Code: (GER.6)

There is a process by senior management to ensure a range of resources to support all efforts to monitor and improve quality. The support is demonstrated through:

*Continued*
Criteria:
- Promote interaction of senior management with working groups in the units
- A system of training, coaching and feedback
- Support the development of: Patient Safety, humanization, risk management and technology management
- Identification and removal of barriers to improvement
- Recognition of the work of the organization’s functional units

**Standard 94. Code: (GER.7)**

The organization ensures a structured, implemented and evaluated process for the development and achievement of the goals and objectives of the operational plans.

| 5 | 4 | 3 | 2 | 1 |

Criteria:
- They are consistent with the values, mission and vision of the organization.
- They provide guidance to the customer care process.
- They are consistent with care process of the customer and family.
- They have a system for monitoring, standardization and a tracking method.

**Standard 95. Code: (GER.8)**

The management of the organization guarantees a series of processes so that the functional units work towards the achievement of the policy and organizational objectives, fostering in each their autonomous development of management, monitoring and measurement of processes. Management should ensure continued support, maintenance and monitoring of these patient-centered goals.

| 5 | 4 | 3 | 2 | 1 |

**Standard 96. Code: (GER.9)**

The organization ensures the implementation of the policy of humanization, compliance with the Code of Ethics, compliance with the Code of good governance and the implementation of the duties and rights of the internal customer and patient and family.

Some of the rights of internal customers and the patient and family are:

Criteria:
- Personal dignity
- Privacy
- Security
- Respect
- Communication

**Standard 97. Code: (GER.10)**

A mechanism is implemented and evaluated at the organizational level to prevent and control aggressive and abusive behavior of workers and patients, their families and caretakers, toward other customers, families, visitors and staff. The process includes:

Criteria:
- A clear policy by senior management to define standards of behavior towards customers and coworkers
- A clear policy to protect associates against aggressive and abusive behavior of customers
- A mechanism to evaluate the cases and determine actions that may be required
- A mechanism to assist those who have been or are victims of abuse or aggressive behavior within their stay in the institution. This includes all associates of the organization, practical training staff, teachers and researchers
- An explicit mechanism to report aggressive behaviors and abuses to the competent authorities
Continued

- Internal clients and patients and their families or caretakers know the mechanism to report when they are attacked during their stay in the organization.
- The organization has a strategy to educate associates and customers who showed abusive or aggressive behavior towards others. This includes practical training staff, teachers and researchers.
- The organization has a mechanism for monitoring these cases and a strategy to manage recurrences.

**Standard 98. Code: (GER.11)**

A process for the allocation and management of financial, physical, technological resources and human talent, according to the planning by the organization of each process and each functional unit. This is achieved through:

<table>
<thead>
<tr>
<th>Criteria</th>
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<tbody>
<tr>
<td>- Review of priorities in the strategic plan</td>
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<tr>
<td>- Evaluation of quality provided to customers during the care process</td>
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<tr>
<td>- Evaluation of available resources</td>
</tr>
<tr>
<td>- Assessment between supply and demand</td>
</tr>
<tr>
<td>- Analysis of budgets</td>
</tr>
<tr>
<td>- Evaluation of costs</td>
</tr>
</tbody>
</table>

**Standard 99. Code: (GER.12)**

A process is implemented and evaluated for the protection and control of resources, linked to risk management. It is achieved by:

<table>
<thead>
<tr>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>- Monitoring the organization’s budget, the budget of strategic plans and operational plan</td>
</tr>
<tr>
<td>- Portfolio monitoring and management</td>
</tr>
<tr>
<td>- Systematic analysis and management on results of financial indicators</td>
</tr>
<tr>
<td>- Assessing the impact of the strategic plan and operational plans</td>
</tr>
<tr>
<td>- Productivity analysis</td>
</tr>
<tr>
<td>- Cost analysis</td>
</tr>
<tr>
<td>- Inventory management</td>
</tr>
<tr>
<td>- Insurance management</td>
</tr>
<tr>
<td>- Promoting the culture of good use of resources</td>
</tr>
<tr>
<td>- Implementation of the Code of Ethics in the use of resources</td>
</tr>
<tr>
<td>- Audit and process improvement</td>
</tr>
<tr>
<td>- Tracking contingencies covered by occupational accidents, occupational diseases and traffic accidents, among others,</td>
</tr>
<tr>
<td>- Audit and monitoring the payment of disability</td>
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</tbody>
</table>

**Standard 100. Code: (GER.13)**

When the organization decides to delegate the provision of a service to a third party, it should ensure that:

<table>
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<tr>
<th>Criteria</th>
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<tbody>
<tr>
<td>- Before hiring a third party, the organization has defined the requirements, service agreements, processes for conflict resolution and mechanisms for evaluating the quality of provision. The third party previously knows the criteria under which he or she will be evaluated.</td>
</tr>
<tr>
<td>- The third party hired is articulated and aligned with the philosophy of accreditation and integrates the applicable standards in the administrative and care services provided, as appropriate, in coordination with the organization.</td>
</tr>
<tr>
<td>- The organization routinely conducts evaluations of the third parties and, according to the results, the third party generates an improvement plan which is monitored by the organization over time.</td>
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<tr>
<td>- There are participatory mechanisms for improving the quality of services provided by the third party.</td>
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</tbody>
</table>
### Standard 101. Code: (GER.14)

The organization plans, develops and evaluates the teaching-service relationship, practical training and research.

<table>
<thead>
<tr>
<th>Criteria:</th>
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</thead>
<tbody>
<tr>
<td>• Consideration of current regulations and requirements, particularly related to educational accreditation.</td>
</tr>
<tr>
<td>• Identification of resources for practical training</td>
</tr>
<tr>
<td>• Development of research according to complexity and institutional vocation to generate knowledge</td>
</tr>
<tr>
<td>• Specific activities for monitoring the teaching-service relationship and practical training staff</td>
</tr>
<tr>
<td>• Assessment and cost-effectiveness of the teaching-service relationship and research</td>
</tr>
<tr>
<td>• Assessment and adjustment of infrastructure for service delivery and development of practical training staff activities</td>
</tr>
</tbody>
</table>

### IMPROVEMENT STANDARD

### Standard 102. Code: (GERMCC1)

Management of improvement opportunities considered in the organizational process of continuous improvement, which apply to the group of standards is developed considering:

<table>
<thead>
<tr>
<th>Criteria:</th>
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<tbody>
<tr>
<td>• The organizational approach to continuous improvement</td>
</tr>
<tr>
<td>• The implementation of prioritized improvement opportunities and removing barriers to improvement by self-assessment teams, improvement teams and other associates of the organization</td>
</tr>
<tr>
<td>• The articulation of opportunities for improvement that relate between different processes and groups of standards</td>
</tr>
<tr>
<td>• Monitoring the results of improvement, verification of cycle closure, quality maintenance and assurance</td>
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<tr>
<td>• Communication of results</td>
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</table>
7.4 GROUP OF HUMAN TALENT MANAGEMENT STANDARDS

Standards 103 to 118

INTENTION OF THE GROUP OF HUMAN TALENT MANAGEMENT STANDARDS (TH)

The expected outcome when an institution obtains compliance with the standards of this group is:

- Human talent improves its skills and performance in relation to institutional goals and purpose, particularly in user care. To do this, the organization has processes of:
  - Identification and effective responses to the needs of human talent
  - Planning of institutional human talent
  - Development of strategies to promote patient safety, humanization of care and risk approach
  - Continuing education
  - Evaluation of skills and performance
  - Improvement of occupational health and safety
  - Systematic evaluation of internal customer satisfaction
  - Development of cultural transformation

This includes:
- Ensuring competence of human talent in the role it plays in the institution
- Empowering human talent to assume the responsibilities assigned
The human talent standard includes:

- Adjust the workstations and areas to improve the performance of the institution’s associates
- Develop strategies to promote communication and ongoing dialogue
- Implement strategies to assess cultural transformation

- Implement human talent processes, including all associates of the institution, regardless of the type of linkage
- Adjust the areas and workstations to improve the performance of the institution’s associates
- Develop strategies to promote communication and ongoing dialogue
- Implement strategies to assess cultural transformation

- The organization increasingly achieves better results in the performance of human talent aligned with the institutional objectives and goals. To this end, the organization develops a plan to improve the processes of strategic direction, systematically, based on the continuous quality improvement cycle. This includes:
  - The definition of a plan with goals and strategies, based on information obtained from the health team, the patient and family
  - The identification of priority care processes and implementation of improvement activities in accordance with priorities
  - The monitoring of process improvement by measuring results
  - The dissemination and deployment of the improvement outcomes to workers of the institution
- If the institution provides training to practical training staff, it covers:
  - Assessment of the teaching-service relationship
  - Articulation of the educational institution in the organization’s accreditation processes
  - Research development
HUMAN TALENT MANAGEMENT STANDARDS

Standard 103. Code: (TH1)

There are processes to identify and respond to the needs of human talent in the organization consistent with the values, mission and vision of the organization. These processes include information related to:

Criteria:

- Legislation
- Periodic evaluation of expectations and needs
- Periodic evaluation of organizational climate
- Periodic evaluation of competence and performance
- Aspects related quality of life at work
- Analysis of workloads, shifts distribution, breaks, fatigue assessment and occupational hazards
- Analysis of workstations
- Call, selection, engagement, retention, promotion, monitoring and retirement
- Compensation Policies and definition of pay scale
- Incentives
- Labor wellbeing
- Needs of organizational communication
- Aspects related to the transformation of organizational culture
- Teaching-service relationship
- Effectiveness of response

Standard 104. Code: (TH2)

There is a process for human talent planning. The process described considers aspects such as:

Criteria:

- Legislation
- Changes in strategic direction
- Improving Patient Safety, humanization, risk management and technology management. Changes in organizational structure
- Changes in the physical infrastructure
- Changes in the complexity of services
- Availability of resources
- Technology available
- Adequacy of human talent in relation to the portfolio and demand for services
- Teaching-service relationship
- Relationship of supply and demand for services with teaching-service
- The planning of human talent in the organization is based on customer needs, rights and duties, the Code of Ethics and Code of good governance and the design of the care process
- Assessment of need for hiring third parties.

Standard 105. Code: (TH3)

The allocation of human talent responds to the planning and stages of the care process, and it takes into account:

Criteria:

- Requirements and job profile
- Identification of workload patterns
- Distribution of shifts, breaks, fatigue assessment and occupational hazards
• Changes in supply and/or demand for service
• Relocation and promotion of staff in the event that a situation so requires
• Supervision of staff training, if applicable
• Allocation of replacements in case of orientation, re-orientation, training, calamities, holidays and leave, among others
• The processes mentioned in the standard should include those aspects directly related to the processes inherent to customer care during each step or phase of care

**Standard 106. Code: (TH4)**

There is a process to ensure that the human talent of the institution, professional and non-professional, has the competence to develop the activities. These skills also apply to the services contracted with third parties and it is the responsibility of the hiring organization to document verification of those competencies. Competencies are defined based on the expectations of the job and they include:

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<th>Criteria</th>
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<tbody>
<tr>
<td>Education</td>
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<td>Licensing or certification, if applicable</td>
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<td>Experience required</td>
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<td>Skills</td>
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<tr>
<td>Interpersonal Relations</td>
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<tr>
<td>Competencies should include: Patient Safety, humanization, risk management and technology management and quality improvement</td>
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<td>Human talent related to teaching and research has the skills for the practical training assigned</td>
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**Standard 107. Code: (TH5):**

There is a mechanism designed, implemented and systematically monitored to verify that background, credentials and privileges of the organization’s associates are defined, which include:

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<th>Criteria</th>
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<tbody>
<tr>
<td>Prioritization of associates related to the care process and those involved in practical training activities, teaching and research</td>
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<td>Sources of information on background and credentials are corroborated</td>
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<td>Handling of the records of employees guarantees:</td>
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<tr>
<td>Privacy and security</td>
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<tr>
<td>Control in access to the records</td>
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<tr>
<td>Consent of associates to access their records. This consent does not apply to the execution of the organization’s own daily activities of human talent management.</td>
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**Standard 108. Code: (TH6)**

There is a process designed, implemented and evaluated for education, training and ongoing instruction that promotes staff competencies according to the needs identified in the organization, including:

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<tr>
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</thead>
<tbody>
<tr>
<td>Strategic Management</td>
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<tr>
<td>Orientation and reorientation</td>
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<tr>
<td>Working environment and responsibilities</td>
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<tr>
<td>Regulations, statutes, policies, standards and processes</td>
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<tr>
<td>Code of Ethics and Code of Corporate Governance</td>
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Continued
- Care model
- Service portfolio
- Organizational structure
- Expectations of performance
- Requirements of activities in occupational health, safety and infection control
- Patient safety, humanization, risk management and technology management
- Strategies to improve the quality of care and service
- Requirements for teaching and research activities, if applicable
- Concepts and tools for quality and process improvement
- Clinical Committees
- Continuing education reinforces the concepts, procedures and policies related to the process of care to customer and family
- The training program has resources; it is implemented, evaluated and adjusted periodically
- Educational institutions with which there are teaching-service agreements are articulated with the training plan
- The program includes an evaluation system that allows demonstrating understanding of content and results
- If it has hired the service with a third party, the contractor must ensure that staff that works there is trained on issues that the organization deems appropriate. These issues should be aligned with institutional training plan and the needs of the service model.

**Standard 109. Code: (TH7)**

The organization ensures the systematic and periodic evaluation of the competence and performance of human talent in the institution, professional and non-professional, caregiver, administrative, teachers and researchers, if applicable, and third parties, if applicable.

Criteria:

- The competence is evaluated at the start of the selection process.
- The performance is evaluated and documented during the trial period, if applicable.
- Improvement of the competence and performance is periodically reviewed and documented in accordance with legal and organization requirements.
- For staff in practical training, teacher and researcher compliance with organizational policies will be assessed.
- Feedback is provided to the people evaluated.
- The evaluation system is made known to each person from the moment of joining the organization.

**Standard 110. Code: (TH8)**

The organization has strategies to ensure compliance with the responsibility entrusted to associates. The strategies relate to:

Criteria:

- Training or periodic certification of associates of the organization in aspects or issues identified as priorities such as:
- Compliance with responsibilities assigned
- Steps or phases of care process
- Patient Safety
- Humanization of service
- Communication skills
- Risk focus
- Management of technologies
- Protocols and guidelines for care
- Scientific Research
- Training of students, if applicable
Standard 111. Code: (TH9)
The organization promotes, develops and evaluates an effective communication strategy (timely, accurate, complete and understood by the recipient) between functional units, between offices (if applicable) and between clinical and non-clinical services at all levels. The mechanisms are incorporated in the policies of human talent.

Standard 112. Code: (TH10)
In talent management the institutional cultural transformation is analyzed, promoted and managed.

Criteria:
- Assessment of organizational culture is performed.
- Key elements of culture that should be improved are identified.
- Improvement actions are prioritized to impact cultural transformation.

Standard 113. Code: (TH11)
The organization promotes, develops and evaluates strategies to maintain and improve the quality of life for employees. It includes:

Criteria:
- Humane treatment, warm, courteous and respectful
- Consideration of personal and family environment
- Analysis of the risk landscape
- Compensation, incentives and wellbeing
- Measurement of fatigue and burnout
- Workload, shifts and rotations
- Working environment
- Addressing occupational disease
- Preparing for retirement and labor retirement
- Improvement of occupational health

These criteria are also considered for staff in practical training, teachers and researchers.

Standard 114. Code: (TH12)
The organization has a systematic process for periodically evaluating associates’ satisfaction and organizational climate. This considers whether:

Criteria:
- It encourages and respects the opinions of the associates.
- From the evaluated results improvement plans are generated, which will be monitored over time for compliance.

Standard 115. Code: (TH13)
There are standardized processes for planning, formalization, implementation, monitoring, evaluation and cost-benefit analysis of the teaching-service relationships and research and provision of optimal health care service.
### Standard 116. Code: (TH14)

Processed are planned, implemented and evaluated for monitoring, counseling, privileges, authorizations and support to staff in practical trainings during the processes of direct contact with the patient, if applicable.

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### Standard 117. Code: (TH15)

The number of persons in practical training per user is established, taking into account the respect for patient rights, privacy, dignity and security.

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</table>

### STANDARD OF IMPROVEMENT

### Standard 118. Code: (THMCC1)

The organization ensures processes consistent with the strategic direction to identify and respond to needs related to the physical environment, generated by the processes of care and by the institution’s internal and external customers, and to evaluate the effectiveness of the response. This includes:

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</table>

Criteria:

- The organizational approach to continuous improvement
- The implementation of prioritized improvement opportunities and removal of barriers to improvement
- The articulation of opportunities for improvement that relate between different processes and groups of standards
- Monitoring of the improvement outcomes, verification of cycle closing and quality assurance
- Communication of results
SECTOR UNIT FOR STANDARIZATION IN HEALTH

Accreditation Standards Committee

OUTPATIENT AND HOSPITAL ACCREDITATION MANUAL

Accreditation Manual
Version 003
7.5. GROUP OF PHYSICAL ENVIRONMENT MANAGEMENT STANDARDS

Standards 119 to 129

INTENTION OF THE GROUP OF PHYSICAL ENVIRONMENT MANAGEMENT STANDARDS (GAF)

The expected outcome when an institution complies with the standards of this group is:

- Business processes, and particularly patient care, have the physical, technological and infrastructure resources and with the technical features that meet the needs. In particular the conditions of the physical environment ensure protection in a humane environment for users and associates. To do this, the organization has processes of:
  - Management of provisions and supplies
  - Management of the physical infrastructure
  - Environmental management
  - Plan for emergencies and internal and external disasters
  - Industrial safety and occupational health

This includes the safe handling of the physical environment with risk approach, consistent with the strategic direction and the promotion of an institutional culture for the good management of the physical environment.
PHYSICAL ENVIRONMENT MANAGEMENT STANDARDS

Standard 119. Code: (GAF1)

The organization ensures processes consistent with the strategic direction to identify and respond to the needs related to the physical environment, generated by the processes of care and by internal and external customers of the institution, and to evaluate the effectiveness of the response. This includes:

Criteria:

- Processes consistent with the values, mission and vision of the organization
- Risk focus
- Improvement of industrial safety
- Preparation, evaluation and improvement of emergency and internal and external disaster response capacity
- The existence of a plan of reallocation of the physical environment as needed and considering the balance between supply and demand
- The organization has designed, disseminated and implemented a plan that guarantees protection to users and associates
- Prevention programs aimed at users and officials for biological, chemical, radiation and mechanical risk, etc.
- Conditions for the humanization of the physical environment.

Standard 120. Code: (GAF2)

The organization ensures safe handling of the physical environment.

Criteria:

- The organization has a strategy to promote institutional culture for the good management of the physical environment.
- It offers training programs in management of the physical environment for associates and users.
- The organization has established a mechanism to identify and investigate incidents and accidents involving unsafe handling of the physical environment. Due to the above, strategies are generated to prevent recurrence.
- The organization has cleaning and disinfection protocols that are reviewed and adjusted periodically. These protocols are known by staff that applies them and by the people that the organization deems appropriate. Understanding and application of these protocols are evaluated periodically.
- Protocols for reuse cases
- Process for safe sterilization
- Guidelines for the safe use of hospital clothing and assessment of compliance
- Safe handling of food service
- Conditions of physical space for isolation
- Compliance with legislation on hospital safety

Standard 121. Code: (GAF3)

The organization ensures processes to identify, evaluate and improve environmental management. It includes:

Criteria:

- Environmental Stewardship Policy
- Development of an ecological culture
- Rational use of environmental resources (utilities, etc.)
- Recycling
- Risks of environmental pollution
- Organization’s contributions to environmental conservation
- Environmental impact assessment from the management of the organization
Standard 122. Code: (GAF4)
The organization ensures the design, implementation and evaluation of processes for safe waste management. The processes consider:

Criteria:
- Identification, classification and separation of waste at the source and at the final destination
- Definition and implementation of a management plan, storage and disposal of hazardous or infectious material (liquid, solid or gaseous) according to classification
- Environmental impact
- Protection elements for staff
- Recycling and marketing of materials
- Potential impact of inadequate management of adverse events on the client
- Information and education to users and their families about the safe handling of waste, as applicable
- The organization should ensure that there are processes for proper waste disposal once they leave the physical facilities of the same. This includes ensuring that they do not pose a risk to any community outside the organization. This guarantee must be explicit, even if it has hired a delegate company responsible for the disposal of waste.
- The organization provides training, coaching, assessment of knowledge and tracking of disposal and segregation of waste to all staff of the institution.
- Regular and systematic monitoring of risks and adherence to safe waste management and implementation of improvements

Standard 123. Code: (GAF5)
The organization has processes of preparing, evaluating and improving the ability to respond to emergencies and internal and external disasters.

Criteria:
- Development and ongoing review of organizational preparedness plan for emergencies and disasters
- The plan covers all functional units and is articulated with all the offices of the organization, if applicable
- Regular exercises are performed of the plan for emergencies and disasters, from which improvement actions are implemented and it is ensured that recommendations are implemented
- Institutional coordination of the emergency and disaster plan provides resources and activities for timely response
- There are contingency plans in case of failure of communication systems
- Information necessary for implementing the plan is collected and disseminated
- Relations with emergency and disaster agencies
- The institution ensures information and education to users and their families to prepare for emergencies and disasters
- There is a process for receiving groups of people involved in an emergency or disaster. The process includes:
  - Provision of areas for the reception of those affected
  - Recording of the names and identification numbers of customers at entry
  - Implementation of a triage system
- Signage of the area prepared to cater to the user group
- Enabling of discharge protocols for hospitalized patients who may be removed to accommodate new entrants
- A formal communication system between the organization serving the emergency, patients and their families
- There is a process for preventing and responding to fires
- The process is consistent with the approved codes
- Education to employees of the organization about plans in case of fire, location and use of fire suppression equipment and evacuation methods
- Activation of alarms and emergency notification to associates and customers of the organization as well as the fire department
- Evacuation of users at risk
- Instructions on the use of communication systems and use of elevators
- Evacuation Systems
- Signaling of evacuation systems
- Processes of disconnection of gases or flammable substances in services
- The institution ensures information and education to users and their families for preparation in case of fire
- An evaluation system of drills and the definition of actions against deviations found
### Standard 124. Code: (GAF6)

Processes are designed, implemented and evaluated for evacuation and relocation of users (when the situation warrants it). The process includes:

**Criteria:**
- Identification of users who must be relocated
- Communication of this situation to families
- Transport system of users
- Arrangements for alternate places for the relocation of the customer, including care staff

### Standard 125. Code: (GAF7)

The organization minimizes the risk of users getting lost through its infrastructure and organizational procedures during the process of care. In the case of a patient getting lost, there is a process designed, implemented and evaluated for handling this situation. The process includes:

**Criteria:**
- Identification of users with the possibility to roam and get lost within the institution
- Signaling and meeting places that facilitate the location
- Security mechanisms for locating patients
- A communication system in the organization for customer identification
- Appointment of a person responsible for the search
- Search protocol in all areas of the organization
- Contact with the Police and the patient’s family

### Standard 126. Code: (GAF8)

The organization promotes a no smoking policy and has banned cigarette smoking in the organization’s facilities.

### Standard 127. Code: (GAF9)

The organization promotes, implements and evaluates actions for the physical environment to ensure conditions of privacy, respect and comfort for humanized care, considering users and associates. It includes:

**Criteria:**
- Conditions of humidity, noise, lighting
- Promotion of quiet conditions
- Suitable, simple and adequate signage
- Adequate work environment
- Reduction of visual and environmental pollution
- Entry areas that take into account the limitations of users
- Comfortable waiting rooms

### Standard 128. Code: (GAF10)

In new constructions and renovations, advances in design, current technologies, security conditions, respect for the environment and existing standards are taken into account.
Criteria:

- Contingency plans are defined to ensure safety in renovation and repair processes, etc., including isolation of noise and pollution.

### STANDARD OF IMPROVEMENT

**Standard 129. Code: (GAFMCC1)**

Management of improvement opportunities considered in the organizational process of continuous improvement, which apply to the group of standards, is developed considering:

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<th>Criteria:</th>
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<td>The organizational approach to continuous improvement</td>
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<tr>
<td>The implementation of prioritized improvement opportunities and removal</td>
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<td>of barriers to improvement, by self-assessment teams, improvement teams</td>
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<td>and other organization associates</td>
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<tr>
<td>The articulation of opportunities for improvement that relate between</td>
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<td>different processes and groups of standards</td>
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<td>Monitoring of the results of improvement, verification of cycle closure,</td>
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<td>quality maintenance and assurance</td>
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<td>Communication of results</td>
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SECTOR UNIT FOR STANDARIZATION IN HEALTH Accreditation Standards Committee OUTPATIENT AND HOSPITAL ACCREDITATION MANUAL Accreditation Manual Version 003
7.6 GROUP OF MANAGEMENT TECHNOLOGY STANDARDS

Standards 130 to 139

**INTENTION OF THE GROUP OF TECHNOLOGY MANAGEMENT STANDARDS (GT)**

The expected outcome when an institution obtains compliance with standards of this group is:

- Business processes, and particularly patient care, are supported by technology management, aimed at efficiency, effectiveness and safety, in a context sensitive to the needs of users and associates. To this end, the organization has processes of:
  - Management of biomedical equipment
  - Management of drugs and medical devices
  - Improved technical surveillance and pharmacovigilance management
  - Incorporation of new technologies
  - Management of information technology
  - Management of support technologies

This includes the safe use of technology, with a focus on risk, consistent with the strategic direction and the promotion of institutional culture for the good management of technology.
### TECHNOLOGY MANAGEMENT STANDARDS

#### Standard 130. Code: (GT1)

The organization has a process for technology planning, management and assessment.

<table>
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<tr>
<th>Criteria:</th>
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</thead>
<tbody>
<tr>
<td>• Regulatory aspects</td>
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<tr>
<td>• Analysis of the supply-demand relationship</td>
</tr>
<tr>
<td>• Needs of payers, users and health team</td>
</tr>
<tr>
<td>• Development needs in accordance with the strategic plan, the institutional vocation, staffing and the projection of the institution</td>
</tr>
<tr>
<td>• Market conditions</td>
</tr>
<tr>
<td>• The analysis and intervention of risks associated with the acquisition and use of technology</td>
</tr>
<tr>
<td>• The analysis for the incorporation of new technology, including: evidence of safety, availability of information on manufacturing, reliability, pricing, maintenance and support, additional investments required, comparisons with similar technology, lifetime, warranties, manuals, representation and other factors that contribute to efficient and effective incorporation</td>
</tr>
<tr>
<td>• The articulation of intervention in infrastructure technology</td>
</tr>
<tr>
<td>• The definition of the technologies to be used for promotion and prevention and public health actions</td>
</tr>
<tr>
<td>• The definition of the organizational, management and support systems (engineering, architecture, etc.) for the use of technology</td>
</tr>
<tr>
<td>• The definition of technologies to be used in habilitation and rehabilitation</td>
</tr>
<tr>
<td>• The facilities, comfort, privacy, respect and other items for the humanization of care with available technology and information about benefits and risks for users</td>
</tr>
<tr>
<td>• Professional and technical staff members who know the subject and integrate those responsible for technology management in the different services</td>
</tr>
<tr>
<td>• Knowledge of management technology for those responsible for use</td>
</tr>
<tr>
<td>• The evaluation of efficiency, cost-effectiveness, safety, environmental impact and other factors of technology assessment.</td>
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</table>

#### Standard 131. Code: (GT2)

The organization has a defined, implemented and evaluated organizational policy for the acquisition, incorporation, monitoring, control and replacement of technology. It includes:

<table>
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<th>Criteria:</th>
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<tr>
<td>• Evidence of security</td>
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<tr>
<td>• Reliability assessment, including analysis of failures and adverse events reported by other buyers</td>
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<tr>
<td>• The definition of the lifetime of the technology</td>
</tr>
<tr>
<td>• The warranty offered</td>
</tr>
<tr>
<td>• Security conditions for use</td>
</tr>
<tr>
<td>• Manuals translated and the information necessary available to ensure the optimal use of technology</td>
</tr>
<tr>
<td>• Support, including support type and time guaranteed (spare parts, software and updates, among others)</td>
</tr>
<tr>
<td>• Maintenance needs and intervals</td>
</tr>
<tr>
<td>• Alternatives available</td>
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<tr>
<td>• Projections of new needs</td>
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<tr>
<td>• Validation by trained staff to verify compliance with the technical specs, that it is complete and working correctly</td>
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<tr>
<td>• Evaluation of cost-benefit, use and cost-effectiveness of the technology</td>
</tr>
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</table>

#### Standard 132. Code: (GT3)

The organization has a process that is designed, implemented and evaluated to ensure the safe use of technology. It includes:

<table>
<thead>
<tr>
<th>Criteria:</th>
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Criteria:
- The assessment and intervention of the main risks of use of the technology available in the institution
- The management of adverse events associated with the use of technology, including training in patient safety, reporting systems, causal path analysis, evaluation of technical surveillance reports, pharmacovigilance, haemovigilance and monitoring of improvement actions implemented and the decisions of third parties taken in relation to the technology used
- Dissemination of information to associates about safe use of technology and the prevention of major risks associated with the use
- Informing to users about risks of technology and their participation in the prevention of risks associated to them
- The systematic review of the state, maintenance and technical support for the operation of technology in optimal conditions
- Training in the use of technology, which guarantees understanding of the professional using it and maintenance of safety conditions, according to vendor specifications, recognition of malfunctions and mechanisms to correct or report them
- Immediate notification of faults and measures to avoid additional damage to technology or adverse events to people
- The inventory assessment, life, availability of spare parts, etc.
- Continuity of care in contingency cases for failure or damage
- The evaluation, monitoring and improvement of the measures implemented

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<thead>
<tr>
<th>Standard 133. Code: (GT4)</th>
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<tr>
<td>The organization has a defined, implemented and evaluated policy for the start of operation, monitoring and control of technology.</td>
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<th>Standard 134. Code: (GT5)</th>
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<tr>
<td>The organization ensures that the maintenance process (internal or delegated to a third party) is planned, implemented and evaluated:</td>
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Criteria:
- The process is planned, it has the necessary coverage for all the technology required and there is support and documentation that backs it.
- It is evident that the staff responsible for this work has the necessary training.
- Downtime of equipment for maintenance or damage is evaluated and contingency measures are taken.
- All technologies under maintenance or repair have a decontamination process prior to use, if the situation warrants it.
- The staff using the technologies is informed of the time needed for maintenance and interventions.
- Information is given to the user, if the situation requires it.

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<th>Standard 135. Code: (GT6)</th>
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<td>The organization has a defined, implemented and evaluated policy for the renewal of technology that includes:</td>
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Criteria:
- Analysis of the costs of repair or maintenance, obsolescence and availability of spare parts for the technology to be renewed
- Benefits compared to new technologies
- Reliability and security
- Ease of operation
- Coordination with strategic direction
- Facilities and benefits for associates who use the technology and users to whom it is addressed
## Standard 136. Code: (GT7)

In institutions with network integrated offices, network management must strive towards unification of clinical support technologies (e.g. lab) and administrative support (e.g. billing systems) and avoid duplication of information or spending unnecessary resources. The management of the network has mechanisms for planning, operationalization and evaluation of programs to identify the best assessment of costs and benefits in the use of technology among different providers that are part of the network, according to the complexity of providers.

### Criteria:

- This standard does not relieve any of the different providers that are part of the network of satisfying the other standards and sections described in this manual.
- The planning and management of the standard, while it should be centralized headed by the network, does not mean that the institutions that comprise it are not part of the planning, monitoring and improvement of these processes, according to the guidelines issued by the network management.
- The standard must be fulfilled regardless of whether the physical facilities of the different providers are owned or not by the organization that manages the network.

## Standard 137. Code: (GT8)

The management of the network has mechanisms for planning, operationalization and evaluation of programs to identify the best assessment of costs and benefits in the use of technology among different providers that are part of the network, according to the complexity of providers.

## Standard 138. Code: (GT9)

The institution must ensure that the use of medical devices and equipment with the latest technology in dentistry, laboratory, diagnostic imaging, blood bank, qualification and rehabilitation has been incorporated into the clinical management guidelines and/or protocols.

## IMPROVEMENT STANDARD

## Standard 139. Code: (GTMCC1)

Management of improvement opportunities considered in the organizational process of continuous improvement, which apply to the group of standards, is developed considering:

### Criteria:

- The organizational approach to continuous improvement
- The implementation of prioritized improvement opportunities and removal of barriers to improvement by self-assessment teams, improvement teams and other associates of the organization
- The articulation of opportunities for improvement that relate between different processes and groups of standards
- Monitoring the results of improvement, verification cycle closure, quality maintenance and assurance
- Communication of results
7.7 GROUP OF INFORMATION MANAGEMENT STANDARDS

Standards 140 to 153

INTENTION OF GROUP OF INFORMATION MANAGEMENT STANDARDS (GI)

The expected outcome when an institution fulfills this group of standards is:

- Business processes have the information necessary for decision-making, based on facts and data.
- The implementation of strategies and mechanisms to ensure the security and confidentiality of information, evaluation and improvement systems of information management, policies and strategies for the use of new technologies for information management, policies and strategies in managing patient medical records so that they are available for health teams responsible for the care, centralized unification in institutions organized in the network, the definition of contingency plans in case of failure in primary systems, among others.
- The information referred to in this section includes all organizational processes, user needs, family and community.
- The organization achieves increasingly better results in the performance of management information. For this, the organization develops a systematic information management plan on the basis of the continuous quality improvement cycle.
The **organization** develops an **information management plan** systematically, on the basis of the **continuous quality improvement cycle**.

- It is useful in the process of information and research. For this purpose, the organization requires processes for:
  - Identification and effective response to information needs
  - Planning information management
  - Data management and implementation of data mining
  - Standardization of information
  - Development and management of clinical records
  - Institutional balanced scorecard
  - Information analysis and decision-making

- Analysis of causes of observed gaps versus expected results
- Safe and reliable use of technology
- Technological support, networks and licensing for the information system
- Implementation based on priorities
- Storage, preservation and depuration of information
- Use of information for decision-making
- Policies of confidentiality and respect in the dissemination of information
- Evaluation of the accuracy and transparency of information
- Risk analysis and assessment of information
- Management support to the information process
- Information system costs and projections
- Information controls and selection of the same
- Organizational communication systems and their effectiveness
INFORMATION MANAGEMENT STANDARDS

**Standard 140. Code: (GI1)**

There are processes to identify, respond to needs and evaluate the effectiveness of information about users and their families, associates, and all processes of the organization. This includes the needs:

Criteria:

- Identified in care processes
- Related to the direction and planning of the organization
- Of resource allocating
- Of teaching-service
- Research
- Public Health
- Promotion and prevention
- Of the patient and family during care
- Improving the quality.

**Standard 141. Code: (GI2)**

There is a process to plan the information management in the organization. This process is documented, implemented and evaluated in an information management plan and it includes:

Criteria:

- Identification of information needs
- An implementation process based on priorities
- The systematic and permanent gathering of the necessary and relevant information to allow the management and each of the processes timely and effective decision making
- Information flow
- Data Mining
- Storage, preservation and depuration of information
- Security and confidentiality of information
- Use of information
- The use of new technologies for information management
- Systematic gathering of the needs, views and levels of satisfaction of information system customers
- Any malfunction in the information system is gathered, analyzed and resolved
- The information supports the management of processes related to the organization’s customer service
- Identification of managerial and technical spaces for the analysis of information
- Definition of corporate indicators including: Patient Safety, humanization, risk management and technology management
- Comparison with best practices
- System of plan measurement, assessment and improvement.

**Standard 142. Code: (GI3)**

When the periodic analysis of information detects unexpected or undesirable variations in process performance, the organization analyzes the causes and generates continuous improvement actions.

Criteria:

- The organization ensures the design and monitoring of protocols to fulfill, if variations are observed.
- The organization has provided the existence of interdisciplinary groups or mechanisms to assess unforeseen variations.
- It conducts follow up on the decisions in relation to a gap in information.
- Emphasis is made on decisions for continuous improvement.
- Actions related to processes are communicated to associates so that they become part of the improvement.
Standard 143. Code: (GI4)

The adoption of information and communications technology will consider:

Criteria:

- Associated costs
- Training to staff
- Ethical aspects
- The relationship between technology and personnel (number of pieces of equipment, coverage, etc.).

Standard 144. Code: (GI5)

Mechanisms are standardized, implemented and evaluated to ensure security and confidentiality of information.

Criteria:

- Security and confidentiality
- Unauthorized access
- Loss of information
- Handling
- Misuse of equipment and information, for purposes other than those legally covered by the organization
- Deterioration, of all types, of the files
- Medical records cannot be left or archived in physical places where access to visitors or unauthorized persons is not restricted
- There is a procedure for assigning passwords
- Existence of information backups and redundant copies
- Document and Records Control
- Information security indicators

Standard 145. Code: (GI6)

A mechanism is implemented, evaluated and formalized to transmit data and information. The transmission guarantees:

Criteria:

- Opportunity
- Ease of access
- Reliability and validity of the information
- Security
- Truth

Standard 146. Code: (GI7)

There are processes for management and data mining that allow obtaining information in a timely, accurate, clear and reconciled manner. This includes:

Criteria:

- The transmission of data
- The definition of the manager for each step in the management of data
- The permissions assigned to each manager
- The validation and reconciliation of data collected and managed in physical and/or electronic form
- The generation of useful information at the operational levels
- The evaluation of the quality and consistency of data generated
### Standard 147. Code: (GI8)

There is a formal mechanism to consolidate and integrate care and administrative information. The healthcare information is information generated from the processes of care to patients and their families.

Criteria:

- This process supports decision making related to the organization.
- The consolidated information is available for comparison with respect to best practices.
- There are indicators that have systematic monitoring.
- The clinical and operational indicators are disseminated, known and used by directly responsible staff.

### Standard 148. Code: (GI9)

The management of information related to clinical records, whether in physical or electronic form, guarantees their quality, safety and accessibility. It includes:

Criteria:

- Order. Legibility and clinicopathological concordance
- Clarity and update of clinical records
- Adequate filing of clinical records and readily available when required
- Systematic and regular audit of the quality of form and content of clinical records
- Guarantee of custody of clinical records
- Single clinical records per user
- Unified numbering and identification system for all clinical records
- Scheme of the transition process to an electronic medical record
- Verification systems to avoid errors in identifying users
- Redundant alarm systems for conditions that warrant them
- Processes for delivering summaries of medical records requested by the competent authorities or the users themselves
- The organization ensures that information management processes make it possible to check if the user has previously attended the institution, on what dates, what professional cared for the user, what tests were ordered, etc.
- When using a mixed care record system (electronic and manual), it must be ensured that there is a single system of patient identification, so that the content of care is available to any provider and any comprehensive audit of the record can be made.

### Standard 149. Code: (GI10)

A contingency plan is designed, implemented and evaluated to ensure the normal operation of the organization’s information systems, whether manual, automated, or both. Any dysfunction in the system is gathered, analyzed and resolved. This includes mechanisms to prevent adverse events related to the management of information systems in particular alarms in medical records.

### Standard 150. Code: (GI11)

It is the responsibility of information management to incorporate the lists of acronyms or abbreviations defined by the organization in the medical care processes and medication management into the computer or information systems. This includes mechanisms to ensure that adverse events associated with the use of acronyms or confusion in the medical orders are prevented.

### Standard 151. Code: (GI12)

Decision making in all processes of the organization is based on the information gathered, analyzed, validated and processed from the management of information.
Criteria:

- There are mechanisms to validate information.
- The information is compared with international benchmarks and adjustments are made (risk, severity, complexity, etc.).
- Clinical and administrative information is articulated.
- Outcomes are based on indicators and trends.
- Institutional improvement processes are supported on validated information that articulates care improvement and management improvement.

**Standard 152. Code: (GI13)**

Education and communication processes are designed, implemented and evaluated, aimed at disseminating information to internal and external customers.

**IMPROVEMENT STANDARD**

**Standard 153. Code: (GIMCC1)**

Management of improvement opportunities considered in the organizational process of continuous improvement, which apply to the group of standards, is developed considering:

Criteria:

- The organizational approach to continuous improvement
- The implementation of prioritized improvement opportunities and removal of barriers to improvement by self-assessment teams, improvement teams and other associates of the organization
- The articulation of opportunities for improvement that relate between different processes and groups of standards
- Monitoring of the results of improvement, verification of cycle closure, quality maintenance and assurance
- Communication of results
7.8 GROUP OF QUALITY IMPROVEMENT STANDARDS

Standards 154 to 158

INTENTION OF THE GROUP OF QUALITY IMPROVEMENT STANDARDS (MCC)

The expected outcome when an institution satisfies this group of standards is:

• The institution has a quality process that generates patient-centered results, both in the technical and interpersonal aspect of care, surpassing the simple process documentation.
• The institution’s quality process systemically integrates the different areas of the organization so that the quality processes developed are effective and efficient.
• The quality processes are closely integrated in the organizational processes and organizational improvement is transformed into quality culture in the organization.
• The quality improvement processes are sustainable over time.
• The processes of improving the overall quality produce learning that is useful for both the organization and the overall system.
Standard 154. Code: (MCC1)

There is an organizational planning process of results-oriented continuous quality improvement, which:

Criteria:

- Has a systemic approach
- Is documented and evidenced by an organizational improvement plan
- Includes improvement opportunities identified in the assessment of compliance with accreditation standards
- Includes opportunities for improvement resulting from the evaluation of the monitoring results and follow-up of clinical and administrative processes and indicators, and audits, coordinated with existing improvement plans
- Articulates improvement opportunities identified in the day-to-day work of the organization with all related processes and existing improvement plans
- Adjusts the different management systems of the organization with the single accreditation system
- Includes the results of the processes of internal and external referral
- Includes opportunities for improvement identified in the relationship with the outsourced third parties
- Includes the allocation of human talent, self-evaluation teams, improvement teams, physical and financial resources and the necessary elements for implementation
- Has people responsible for continuous improvement of organizational processes, who have the skills to guide the development of actions to improve
- The impact of improvement actions on the user and family must be made explicit
- Defines the communication mechanisms of the process and the results of improvement
- Determines the organizational indicators that will be improved after the implementation of opportunities for improvement in organizational processes, considering aspects such as security, continuity, coordination, competence, effectiveness, efficiency, accessibility and opportunity, among others

Standard 155. Code: (MCC2)

The organization implements continuous improvement opportunities identified in the planning process, which:

Criteria:

- Are prioritized using a standardized methodology to consider, at least, those with the greatest impact in terms of user centered and exposure to risk
- Have the support, resources and elements necessary for implementation
- Are operationalized in improvement actions, which are fully completed and in the time allotted in a work schedule
- Identify potential barriers to implementing the improvement actions in order to make the necessary corrections
- Are carried out by associates and/or improvement teams with the necessary competencies for development

Standard 156. Code: (MCC3):

There is a process of continuous quality monitoring and continuous improvement of the organization.

Criteria:

- It has a formal and permanent method of evaluation, data gathering, processing and analysis of results, including risk approach.
- Unwanted performance patterns are analyzed in depth, identifying the root causes of problems and developing methods of solving problems.
- It conducts follow up the results of the indicators that match the opportunities for improvement.

Continued
- It regularly monitors the implementation of improvement opportunities, including those related to third parties.
- It provides feedback to the organization, to those involved in the improvement processes and to management bodies for analysis and decision making.
- It generates results that are input for adjusting the organizational process of continuous improvement.

**Standard 157. Code: (MCC4):**

The results of quality improvement are communicated and the following are considered:

<table>
<thead>
<tr>
<th>Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication to the health team, suppliers, the health promotion organizations (EPS), the patient and family, the community and other entities, as applicable</td>
</tr>
<tr>
<td>Information on the strategies adopted to achieve results and on the results as such</td>
</tr>
<tr>
<td>The appropriate channels for dissemination, awareness and internalization of results through knowledge management</td>
</tr>
<tr>
<td>Strategies to disseminate and/or publish, through internal or external media, the results of improvement</td>
</tr>
</tbody>
</table>

| 5 | 4 | 3 | 2 | 1 |

**Standard 158. Code: (MCC5):**

The results of quality improvement are kept and guaranteed in time in cultural transformation, considering processes that lead to organizational learning and internalization of knowledge, strategies and best practices developed.

| 5 | 4 | 3 | 2 | 1 |