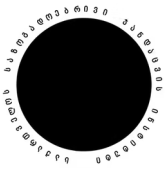

ASF HOSPITAL STANDARDS

Complete Reference — All Nine Standards

Version 3.0 · 2026

Accréditation Sans Frontières
Paris, France · Geneva, Switzerland · Tbilisi, Georgia

ASF-HOSP-STD3-v3.0 · Published Paris, 12 September 2026 · Next review 12 September 2029

Document Control

Document Title	ASF Hospital Standards
Document Reference	ASF-HOSP-STD3-v3.0
Version / Edition	Version 3.0
Status	Published
Date of Publication	12 September 2026
Place of Publication	Paris, France
Issuing Authority	ASF International Standards Council, Accréditation Sans Frontières
Language of Origin	English
Effective Date	12 September 2026
Next Scheduled Review	12 September 2029
Supersedes	Version 2.0 and earlier editions

Foreword

This standard originates from a deliberate policy choice made in Georgia in 2014: to advocate for international healthcare accreditation rather than attempt to replace it. Working through the Public Health Institute of Georgia (PHIG, established 2011), its founders organized the country's first structured accreditation initiative — including expert missions by Joint Commission International — and carried this advocacy directly to Georgia's Ministry of Health over the following years.

That advocacy produced, in 2018, the first draft of a Georgian-adapted accreditation standard, and in 2020, the formal establishment of Accréditation Sans Frontières (ASF) as an international legal entity in Paris, alongside the ASF International Standards Council — the standing body responsible for developing and revising ASF's standards. The Council's methodology is directly informed by the World Health Organization's guideline development process, including WHO's use of the GRADE framework for weighing evidence certainty, adapted to the practical work of accreditation. ASF's founder has served since 2016 as a founding member of the UN Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent, and ASF has been a member of the International Society for Quality in Health Care (ISQua) since 2023.

This advocacy also found regulatory validation in Georgian government policy requiring independent international accreditation of hospitals, formally implemented through Order №4/б (26 January 2023).

Consistent with the structure recognized across major international standards bodies, ASF's work spans four pillars: accreditation of organizations against its published standards, accreditation of the standards themselves through the International Standards Council's ongoing review, accreditation of the surveyors who conduct ASF's own assessments, and accreditation of the training that equips facilities and professionals to meet them, delivered through GMJ Academy. This standard has been developed and refined through consultation with practitioners across multiple continents, and every edition includes a Health & Migration endorsement grounded in WHO's Global Competency Standards for health workers serving refugees and migrants — a commitment ASF treats as non-negotiable. Consistent with ASF's founding principle of accreditation without borders, this standard is published in full and made freely available to any organization seeking to build accreditation capacity in its own country.

This, the third edition, is published in 2026. The ASF International Standards Council reviews and revises each standard on a three-year cycle.

About This Document

This is the complete ASF Hospital Standards reference — nine standards in total. Standards 1 through 7 are mandatory, organised around the patient's actual journey rather than institutional departments: Access & Arrival, Reception & Information, Environment & Shared Spaces, Care & Treatment, Safety & Emergency Preparedness, Aftercare & Follow-up, and Governance & Management. A facility completes all seven before accreditation is possible.

Standards 8 and 9 are optional endorsements — Medical Tourism and Refugee & Migrant Health — layered onto the base standards for facilities that specifically serve those patient populations. Neither is ever issued alone; both assume Standards 1 through 7 are already genuinely met, and add depth on top.

Every criterion in this document follows the same two-page structure: an assessment page (a hospital self-assessment table, and exactly what an ASF assessor will independently check, shown to you in advance) and a guidance page (why the standard exists, what good and failure look like, the most common reasons hospitals score partial, how to implement from zero, and what surveyors specifically look for).

Every criterion carries at least one reference. Numbered references are formal, individually verified Vancouver-style citations; where a criterion instead reflects genuine professional consensus without one attributable paper, that is stated honestly rather than assigned an invented citation. A complete reference list appears at the end of this document, followed by an index.

Radical transparency is the design, not a courtesy: every self-assessment question and every assessor method is published here, in advance, before any visit. This is what makes ASF's model different — everything up to the actual visit is open, and the visit itself is only one day.

Immediately after this page is the Facility Classification chapter — a short questionnaire every facility completes first, sorting itself into one of four types: Crisis, Transitional, Small, or Standard. Every criterion in the standards that follow carries a four-cell strip showing whether it applies in full, in an adapted form, or not at all, for each of these four types.

> **On resource context:** *ASF exists principally to serve small and under-resourced hospitals, and this standard is written for that reality throughout, not only where a single criterion happens to say so explicitly. Where a facility does not yet have full capacity to meet a requirement, a specific, budgeted, dated plan with visible first steps taken — the same principle established in Standard 1.3 — is the intended, acceptable path to a Yellow score across this entire document, not a concession unique to accessibility. Genuine neglect and honestly disclosed resource constraint are judged differently everywhere in this standard, by design.*

On the standard-level scoring threshold: *the rule that a standard scores Red if more than 10% of its CORE criteria score Red is a considered working threshold set during this document's development, not an empirically validated figure. It should be treated as provisional and revisited once real assessment data exists to test it.*

ASF-HOSP-STD3-v3.0 · Published Paris, 12 September 2026 · Next review 12 September 2029

Table of Contents

FACILITY CLASSIFICATION

Which Type of Hospital Are You?

Completed before Standard 1 · Confirmed by the facility · Verified on the assessment visit

Why This Chapter Exists

Every established international accreditation framework was built around a single implicit archetype: a hospital with stable national infrastructure, predictable funding, and a full clinical workforce. This is not a criticism of those frameworks; it reflects the health systems in which they were developed. But applying that same implicit archetype uniformly, everywhere, treats a well-resourced urban facility and a hospital in an active conflict zone as though they face the same starting conditions. They do not, and a standard that pretends otherwise fails both the facility asked to meet it and the patients it is meant to protect.

> *Two failures sit on either side of this problem, and both are real. Demanding the impossible — holding a resource-starved facility to identical requirements as a fully resourced one — guarantees failure and teaches facilities that accreditation is disconnected from their actual world. Excusing the inexcusable — allowing a well-resourced facility to skip basic patient safety because "context" is invoked as a shield — is not equity, it is negligence wearing equity's language. This chapter exists to make the second failure structurally impossible, whichever honest answer is reached about the first.*

Four Hospital Types, Not One

This standard recognises four distinct operating realities. Each is defined by whichever single factor most determines what that hospital can realistically achieve — not by an attempt to score every possible dimension of a hospital's situation at once. A facility is assigned to exactly one category.

Standard (ST) — the reference model

A fully resourced, functioning hospital, comparable to the facilities most existing international frameworks were designed around [14, 2]. This is the baseline against which the other three categories are understood, and the full standard in this document is written to this baseline in full, without adaptation.

> *ASF assesses Standard hospitals, and does so gladly. But Standard hospitals are already well served by existing international and national accreditation frameworks, built for exactly this category. ASF's own reason for existing sits in the three categories that follow, where those frameworks offer little that is genuinely fit for purpose.*

Small (SM) — where scale, not crisis or poverty, is the defining constraint

A facility that is otherwise stable — no conflict, no acute national resource crisis — but whose small size is the real, binding limit on what it can do: a dedicated ethics committee, a full on-site laboratory, or a permanently staffed specialist rotation may simply not be realistic at this scale, regardless of how well-run the facility otherwise is.

This is not a new idea in accreditation. Formally distinct small or rural hospital designations, with their own dedicated accreditation track, formally recognise in multiple countries that a small rural hospital requires a genuinely different, not merely reduced, set of expectations from a large urban one [27, 22]. This standard applies the same logic internationally.

Transitional (TR) — where the constraint is national, not local, and not conflict

A facility in a country undergoing genuine, real infrastructure or funding limitation — unreliable national power, constrained government health financing — but with no active conflict or humanitarian emergency. A hospital with real doctors, real equipment, and real institutional support, working against national-level constraints outside its own control. The World Bank's income classification, an independently maintained and internationally recognised measure, is the anchor for this category, not ASF's own judgement [28, 29].

Crisis (CR) — where the constraint overrides everything else

Active armed conflict or a declared humanitarian emergency. This is deliberately treated as its own category rather than a more severe version of Transitional, because the operating logic of crisis care is categorically different, not merely more difficult. The Sphere Handbook — the most

widely recognised set of minimum standards in humanitarian response, covering health as one of its four core sectors — establishes this same principle: that crisis conditions require their own defined minimum, not a scaled-down version of normal-condition standards [21].

> *A ten-bed post and a hundred-bed hospital in the same active conflict zone face substantially the same defining reality. Splitting Crisis by size would recreate exactly the complexity this four-category structure exists to remove.*

The Universal Floor

A small number of criteria apply identically, in full, in every one of the four categories, with no exceptions available for any reason. This is not a fifth category — it sits beneath all four simultaneously, unaffected by which one applies.

> *A Standard hospital in a wealthy capital and a Crisis facility in an active conflict zone are both held, without exception, to the Universal Floor. Category changes what else is realistic to build toward. It never changes what a patient is owed at the most basic level of safety.*

Criteria on the Universal Floor include, at minimum: correct patient identification [13], genuine hand hygiene practice [41], informed consent as an actual conversation [40], basic falls prevention [8], treatment free of discrimination, and clear marking of the emergency entrance. This list is deliberately short. Everything else in this standard is where category genuinely matters.

Which Type of Hospital Are You?

Answer these questions in order, top to bottom. The moment you answer YES, stop — that is your answer. If you reach the end still answering NO, you are Standard.

WORK DOWN THIS LIST. STOP AT YOUR FIRST YES.			
1	**Is your country in an active war, armed conflict, or a declared humanitarian emergency right now?** *This means fighting, displacement, or a declared emergency is actually happening now — not that things are generally difficult.*	☐ **YES → CR CRISIS**	☐ NO → next question
2	**Does your national government struggle badly to fund hospitals, or is national power or medicine supply unreliable — even though there is no war or crisis?** *This is about your country as a whole, not just your own hospital: national money, national power grid, national medicine supply.*	☐ **YES → TR TRANSITIONAL**	☐ NO → next question
3	**Is your hospital's small size the main reason you cannot offer certain services — for example, no room for a dedicated committee, a full lab, or a permanent specialist?** *This applies even in a stable, well-funded country. The limit here is your own size, nothing else.*	☐ **YES → SM SMALL**	☐ NO → next question
If you answered NO to all three questions above: You are **STANDARD (ST)** — no crisis, no national constraint, and size is not holding you back. This is the fully resourced baseline this standard is written for.			

THIS IS ME

My type: ☐ **CR** ☐ **TR** ☐ **SM** ☐ **ST**

Example: A hospital in Lebanon — no active conflict, so NO to question 1. National power and funding are genuinely unreliable, so YES to question 2. Stop there. This hospital is TR.

> *This page is verified, not just accepted, when the assessor visits. If reality is different from what you ticked, the classification is corrected on the spot — nothing about that is a problem.*

The Rules Behind This Page

This section exists for anyone who wants to see exactly why the questions are ordered the way they are. You do not need to read it to use this standard.

Why Crisis is asked first

Crisis overrides every other consideration, so it is checked first. A hospital in active conflict faces the same defining reality whether it is well-funded or not, large or small — asking about funding or size before conflict would risk misclassifying a hospital whose real, dominant constraint is the crisis itself [21].

Why Transitional is asked second, and is grounded externally

This question is a plain-language proxy for the World Bank's own income classification [28, 29] — not ASF's own judgement. A hospital answering YES here is, in effect, reporting the same reality the World Bank's independently maintained classification would show for its country.

Why Small is asked third, not first

Size only becomes the defining constraint once crisis and national-level limitation have been ruled out. A small hospital in a crisis zone is still classified Crisis — its size is not the binding issue, the crisis is. This ordering, and the recognition that small facilities warrant a genuinely distinct standard rather than a reduced one, follows the same precedent set by dedicated small or rural hospital accreditation tracks recognized in multiple countries [27, 22].

The Universal Floor still applies, regardless of your answer

A small number of criteria — correct patient identification [13], genuine hand hygiene [41], real informed consent [40], basic falls prevention [8], non-discrimination, and clear emergency entrance marking — apply in full to every one of the four types on this page, with no exceptions. Your type changes what else is expected of you. It never changes this list.

Facility Confirmation

Self-declared by the facility, consistent with the radical transparency principle running through this entire standard.

> *Verified, not simply accepted, on the assessor's one-day visit. If the visit reveals a different reality, the classification is corrected before assessment proceeds.*

Facility name: _____
Country: _____
Declared type: ☐ CR ☐ TR ☐ SM ☐ ST
Declared by (name and role): _____
Date: _____
Signature: _____

Revision

Classification is not permanent. Where context or scale genuinely changes — new power infrastructure, expanded beds, an updated World Bank classification — the facility revises and re-confirms. The previous declaration is superseded, not deleted, so classification history remains a visible record of genuine change.

Reading the Strip on Every Criterion

Every criterion from Standard 1 onward carries a four-cell strip — CR, TR, SM, ST — showing how that specific criterion applies to each type. Read it before you read anything else on the page. Three colours, three meanings, and the difference between two of them matters enormously:

FULL **The complete requirement applies. Nothing is reduced.**	**ADAPTED** **A real requirement still applies — genuinely lighter, but not nothing. The hospital must still do something concrete.**	**N/A** **The only status that means no requirement at all. This criterion genuinely does not apply to this type.**

ADAPTED IS NOT PERMISSION TO SKIP. Only N/A means a facility can do nothing about a criterion and still pass. If a criterion shows ADAPTED for your type, you are still being assessed against it — at a genuinely different, stated standard, not a reduced-effort version of your own choosing. Where a criterion's guidance page explains what that adapted standard actually looks like, it is stated explicitly there — never left for the facility to guess or minimise on its own.

A concrete example: Standard 1.2 (Hospital Grounds and Territory Entrance) shows ADAPTED for Crisis. A Crisis-classified facility does not get to ignore the condition of its grounds. What changes is the standard of upkeep expected — full landscaping is not realistic mid-crisis, but the approach still has to be genuinely safe to walk. That is still a real, checkable requirement, assessed on the visit like any other.

STANDARD 1

Access & Arrival

MANDATORY

5 criteria

	Standard 1.1 **NON-NEGOTIABLE** · *Standard 1: Access & Arrival* **Findable Before Arrival**	**ASSESSMENT** *ASF-STD1-v3.0*

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

1.1
NON-NEGOTIABLE
L1

THE STANDARD

Findable Before Arrival

The facility's name, address, phone number, and mapped location are correct, current, and independently verifiable by anyone searching as a patient would.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the facility name, address, and phone number correct on your own website and any public listing?** *Not the address on file with a regulator years ago — what a patient searching today would actually find.* Doc: Website screenshot, public listing	YES	PARTIAL	NO
2	**Does the phone number listed actually connect to your facility when called?** *Tested directly, not assumed because it was correct when first published.* Doc: Call log or test record	YES	PARTIAL	NO
3	**If a map location is used, does the pin match the real entrance, not a nearby approximation?** *A pin one block off sends ambulances to the wrong street in an emergency.* Doc: Map screenshot	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Public search test*	Independently searches for the facility exactly as a patient would — by name, address, phone number — using only public information.
DOCUMENT *Address cross-check*	Confirms the mapped or listed address matches what is physically found on arrival.
ASK *Cold-call directions test*	Calls the listed number posing as a first-time patient asking for directions, and notes whether the answer is accurate without hesitation.

REFERENCES

World Health Organization. Emergency care system framework. Geneva: WHO; 2018.

Pons PT, Markovchick VJ. Eight minutes or less: does the ambulance response time guideline impact trauma patient outcome? J Emerg Med. 2002;23(1):43-48.

Standard 1.1 · *Standard 1: Access & Arrival*

Guidance & Learning

GUIDANCE
ASF-STD1-v3.0

WHY THIS STANDARD EXISTS

A facility that cannot be found cannot be reached in an emergency. Outdated addresses, dead phone numbers, and unmapped locations are a common, preventable failure that costs real time when a patient or ambulance is trying to arrive.

The evidence: World Health Organization. Emergency care system framework. Geneva: WHO; 2018.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Name, address, and phone number are correct and independently verifiable.	✗ An old address still listed on letterhead, alongside a correct current one online.
✓ A patient can call cold and reach the front desk within a minute.	✗ Listed number rings out with no voicemail; no way to confirm the location at all.
✓ The mapped pin matches the real, physical entrance exactly.	✗ A map pin one street over from the real building, with no correction requested.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **The website was never updated after a move.**
The clinical team changed address but nobody told whoever manages the website — a common, low-cost, high-consequence gap.

2 **The phone number is correct but nobody answers as "the facility."**
Calls connect to a generic switchboard that cannot confirm this is the right place.

3 **The map pin was set once, years ago, and never checked again.**
Map platforms occasionally shift pins during their own updates — nobody at the facility owns checking it periodically.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Search for your own facility exactly as a patient would, across every platform patients actually use.

Week 2 Correct the address and phone number on your own website and any listing you control directly.

Week 3 Call your own listed number from an outside line and time how long it takes to confirm you've reached the right place.

Ongoing Recheck all public listings every six months.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Search cold, don't ask the facility for directions first.
The whole point is testing what a stranger finds.

Call from a number the facility won't recognise.
A number in the facility's own contact list may get special handling a real patient wouldn't.

E-LEARNING academy.gmj.ge/std1-1-findability — 30 min · complete before self-assessment

Standard 1.2 **NON-NEGOTIABLE** · *Standard 1: Access & Arrival*

Hospital Grounds and Territory Entrance

ASSESSMENT *ASF-STD1-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.2
NON-NEGOTIABLE
L1

THE STANDARD

Hospital Grounds and Territory Entrance

The hospital's territory begins at its first point of entry — the gate, main entrance, or boundary of the grounds — not at the building door. This entire approach is safe, clean, and clearly the hospital's own space from that first point.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is the boundary of the hospital's grounds — gate, fence line, or first entry point — clearly identifiable as the hospital's own territory?** *Not the building itself — the point where a visitor first enters land the hospital is responsible for.* Doc: Photo of grounds boundary and entry point	YES	PARTIAL	NO
2	**Is the approach from that entry point to the building itself safe, maintained, and clean?** *Walkways, lighting, and general upkeep of the grounds themselves, not just the building interior.* Doc: Grounds maintenance record	YES	PARTIAL	NO
3	**Is there a single, clear route from the territory entrance to the main building, not multiple ambiguous paths?** *A confusing arrival sequence undermines confidence before the visit has even properly begun.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Grounds boundary check*	Physically walks the entire approach from the territory's first entry point to the building, checking maintenance and safety.
OBSERVE *Route clarity test*	Approaches as a first-time visitor would, checking whether the route from entry point to building is unambiguous.
DOCUMENT *Grounds maintenance record review*	Reviews maintenance and upkeep records for the grounds themselves, separate from building maintenance.

REFERENCES

Ulrich RS, Zimring C, Zhu X, et al. A Review of the Research Literature on Evidence-Based Healthcare Design. HERD. 2008;1(3):61-125.

WHO, Emergency Care System Framework (2 May 2018).

Standard 1.2 · *Standard 1: Access & Arrival*

Guidance & Learning

GUIDANCE
ASF-STD1-v3.0

WHY THIS STANDARD EXISTS

A patient's experience of arrival doesn't start at the building door — it starts wherever the hospital's own territory begins. A neglected entrance gate, an unclear boundary, or grounds that don't visibly signal "you have arrived" undermines trust and safety before any clinical encounter even begins.

The evidence: Ulrich RS, Zimring C, Zhu X, et al. A Review of the Research Literature on Evidence-Based Healthcare Design. HERD. 2008;1(3):61-125.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The grounds boundary is clearly identifiable, safe, and well maintained from the first point of entry.	✗ The territory boundary is unclear, with no obvious sense of where hospital responsibility begins.
✓ A single, unambiguous route leads from the entrance to the building.	✗ Grounds are neglected, poorly lit, or unsafe to walk, even though the building itself is well kept.
✓ Lighting, walkways, and general upkeep of the grounds reflect the same standard expected inside the building.	✗ Multiple ambiguous paths from the entrance leave a first-time visitor uncertain which way to go.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 The building is well maintained, but the grounds have never received the same attention.
Maintenance budgets and attention often stop at the building's own walls, leaving the approach overlooked.

2 The main route is fine but a secondary or older entrance is neglected.
A less-used entrance can quietly fall out of the same maintenance cycle as the primary one.

3 Lighting is adequate during the day but poor at night, when it matters most for safety.
A daytime assessment alone can miss a genuine after-hours safety gap.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Walk the full grounds approach, from territory boundary to building, and log every maintenance or safety gap found.

Week 2 Address the highest-priority safety gaps first — lighting, walkway condition, obstruction.

Week 3 Clarify signage or physical routing so the path from entrance to building is unambiguous.

Ongoing Include grounds maintenance in the same routine inspection cycle as the building itself.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Walk the actual approach yourself, don't assess the building alone.
This standard is specifically about what happens before the building door, which is easy to overlook.

Check lighting and safety after dark if possible, not only during a daytime visit.
Genuine safety gaps often concentrate in conditions the standard assessment visit doesn't naturally cover.

E-LEARNING academy.gmj.ge/std1-2-grounds-entrance — 30 min · complete before self-assessment

	Standard 1.3 **NON-NEGOTIABLE** · *Standard 1: Access & Arrival* **Physical Access, or a Real Plan**	**ASSESSMENT** *ASF-STD1-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.3
NON-NEGOTIABLE
L1

THE STANDARD

Physical Access, or a Real Plan

At least one entrance is usable by a wheelchair user without staff needing to lift or carry them. Where full access does not yet exist, the facility holds a specific, budgeted, dated plan to close the gap.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there at least one entrance a wheelchair user can use without staff physically lifting or carrying them?** *A step, a narrow doorway, or a heavy unassisted door all count as a barrier.* Doc: Photo of entrance route	YES	PARTIAL	NO
2	**If not, is there a specific, budgeted, dated plan to close the gap?** *Not "we've discussed it" — a named structural change, a budget line, a date.* Doc: Capital plan or board minutes	YES	PARTIAL	NO
3	**Has any real step already been taken toward that plan?** *A quote obtained, materials ordered, or work scheduled — not just intention.* Doc: Quote, order, or contract	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Physical route check*	Walks the accessible route from the street or car park to the entrance, checking for steps, doorway width, and obstructions.
DOCUMENT *Plan verification*	If access is incomplete, requests the accessibility plan directly.
ASK *Front-line staff interview*	Asks a front-line staff member how they would actually assist a wheelchair user arriving right now.

REFERENCES

United Nations. Convention on the Rights of Persons with Disabilities, Article 9 — Accessibility. New York: UN; 2006.

United Nations. Convention on the Rights of Persons with Disabilities, Article 4(2) — Progressive Realisation. New York: UN; 2006.

Standard 1.3 · *Standard 1: Access & Arrival*

Guidance & Learning

GUIDANCE
ASF-STD1-v3.0

WHY THIS STANDARD EXISTS

Physical access is a real right, not a comfort feature — this stays Non-Negotiable. But this standard applies across very different resource realities. Treating "no ramp yet, funded plan, a date" the same as "no ramp, no plan" would make accreditation achievable only for facilities that already have money.

The evidence: United Nations. Convention on the Rights of Persons with Disabilities, Article 9 — Accessibility. New York: UN; 2006.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A clear, unobstructed accessible route verified on the day of assessment.	✗ "We've been meaning to build a ramp" — no document, no budget, no date, unchanged from the year before.
✓ A funded, dated plan with a contractor already selected and visible first steps taken.	✗ A ramp exists on paper but is blocked by stored equipment on the day of the visit.
✓ Front-line staff describe genuine, dignified assistance procedures without hesitation.	✗ Staff describe assistance as improvised, with no actual procedure or training behind it.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A ramp exists but was never checked for actual usability.**
Grade too steep, surface uneven, or door at the top too heavy — built once, never tested by an actual wheelchair user.

2 **A plan exists in someone's head but was never written down or costed.**
Good intentions with no budget line are indistinguishable from no plan once someone asks for the document.

3 **Access exists at one entrance but staff don't know to direct people there.**
The infrastructure exists; the operational knowledge to use it consistently does not.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Physically test your own accessible route and document every barrier found.

Week 2 Get a real quote for the smallest fix that closes the largest gap.

Week 3 Put a specific budget line and date in front of whoever approves facility spending, in writing.

Month 2 Train front-line staff on a real, dignified assistance procedure for the gap between now and the fix.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Walk the route yourself, don't take a photo's word for it.
Grade and surface texture matter in ways photos hide.

Ask for the plan document before commenting on what you observed.
A facility that produces a real document quickly usually has a real plan.

E-LEARNING academy.gmj.ge/std1-2-access — 30 min · complete before self-assessment

	Standard 1.4 NON-NEGOTIABLE · *Standard 1: Access & Arrival* **Emergency Entrance, Marked and Clear**	ASSESSMENT *ASF-STD1-v3.0*
CR FULL	TR FULL	SM FULL	ST FULL

1.4
NON-NEGOTIABLE
L1

THE STANDARD

Emergency Entrance, Marked and Clear

Where the facility has a distinct emergency entrance, it is clearly marked from the approach a person would actually take, visible before arrival, and kept clear at all times.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the emergency entrance signed clearly enough to be seen before arriving at the main door?** *Visible from the approach a real ambulance or member of the public would take.* Doc: Photo from approach point	YES	PARTIAL	NO
2	**Is the route to it kept physically clear at all times?** *Not just clear when checked — clear as a matter of routine.* Doc: Routine clearance log, if kept	YES	PARTIAL	NO
3	**Would two different staff members give the same directions to it if asked separately?** *Inconsistent directions from staff usually means the signage itself is inadequate.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Approach visibility test*	Approaches from the direction the public or an ambulance would arrive, checking when signage first becomes visible.
OBSERVE *Route clearance check*	Checks whether the route beneath the signage is physically clear.
ASK *Staff consistency test*	Separately asks two different staff members for directions, without either knowing the other was asked.

REFERENCES

World Health Organization. Emergency care system framework. Geneva: WHO; 2018.

United Nations. Convention on the Rights of Persons with Disabilities, Article 9(1)(b). New York: UN; 2006.

Standard 1.4 · *Standard 1: Access & Arrival*

Guidance & Learning

GUIDANCE
ASF-STD1-v3.0

WHY THIS STANDARD EXISTS

In a genuine emergency, seconds spent finding the right door are seconds not spent on care. A sign only visible after arriving at the wrong entrance defeats its own purpose.

The evidence: World Health Organization. Emergency care system framework. Geneva: WHO; 2018.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A sign is visible from the main road, before the turn into the grounds, with the route kept clear. ✓ Staff give the same, immediate, confident directions when asked separately.	✗ Signage only becomes visible once already in the car park. ✗ Two staff members give two different answers when asked directly.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Signage was designed for vehicles, not pedestrians, or the reverse.**
A facility serving both often only signs for one.

2 **The route is clear during the day and blocked by deliveries at other times.**
Assessed once, on a quiet day, the gap between routine and exception can go unnoticed.

3 **Signage exists but wasn't updated when the entrance itself moved.**
Renovation projects change layouts faster than signage budgets get approved.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Walk and drive the actual approach routes, timing when signage becomes visible.

Week 2 Fix the single biggest visibility gap first.

Week 3 Brief all front-line and security staff on a single, consistent set of directions.

Ongoing Recheck route clearance at different times of day.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Time the approach, don't just confirm the sign exists.
A sign visible only for the last five metres fails the same way as no sign.

Ask directions from someone who isn't reception.
Reveals whether the knowledge is actually distributed.

E-LEARNING academy.gmj.ge/std1-3-emergency-entrance — 30 min · complete before self-assessment

Standard 1.5 **CORE** · *Standard 1: Access & Arrival*
Wayfinding Without Staff Dependence

ASSESSMENT *ASF-STD1-v3.0*

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

1.5
CORE
L1

THE STANDARD

Wayfinding Without Staff Dependence

Basic wayfinding allows someone with no prior knowledge of the building to locate reception, toilets, and the main clinical areas without stopping to ask for directions more than once.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Can a first-time visitor find reception using only your posted signage?** *Not staff intercepting and redirecting.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Can they find the nearest toilet and one named clinical department the same way?** *Test this with someone who has genuinely never been inside the building before.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is signage consistent across every floor, or does it stop after the ground floor?** *A common, specific failure.* Doc: Photos, floor by floor	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *First-time visitor test*	Enters as a first-time visitor and attempts to locate reception, toilet, and one department using only signage.
OBSERVE *Staff-query count*	Notes exactly how many times a staff member had to be asked for directions.
ASK *Independent visitor check*	Asks a visitor already in the building whether they found their way easily.

REFERENCES

Carpman JR, Grant MA. Design that cares: planning health facilities for patients and visitors. 3rd ed. San Francisco: Jossey-Bass/Wiley; 2016.

Ulrich RS, Zimring C, Zhu X, et al. A review of the research literature on evidence-based healthcare design. HERD. 2008;1(3):61-125.

Standard 1.5 · *Standard 1: Access & Arrival*

Guidance & Learning

GUIDANCE
ASF-STD1-v3.0

WHY THIS STANDARD EXISTS

This is not a comfort feature. Confusing, unsigned facilities disproportionately fail people who are anxious, in pain, unfamiliar with the local language, or accompanying someone who is.

The evidence: Carpman JR, Grant MA. Design that cares: planning health facilities for patients and visitors. 3rd ed. San Francisco: Jossey-Bass/Wiley; 2016.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Reception, toilets, and at least one clinical area are locatable by signage alone.	✗ A single sign board at the main door and nothing beyond it.
✓ A visitor already in the building confirms wayfinding felt straightforward.	✗ Ground-floor signage is clear; upper floors have none at all.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Signage exists but uses internal department codes, not patient-facing names.**
Staff know what "Ward 4B" means; a first-time visitor does not.

2 **Ground floor is signed because it was renovated recently; upper floors were never touched.**
Wayfinding quality often tracks renovation history rather than a deliberate standard.

3 **Signage exists in one language only, in a facility serving a multilingual population.**
Technically present signage a meaningful share of visitors still cannot use.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Have someone with no prior knowledge navigate the building, and log every point of confusion.

Week 2 Fix the highest-traffic gap first.

Month 2 Extend consistent signage to every floor, using patient-facing names.

Ongoing Re-test with a genuine first-time visitor whenever the layout changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Use a genuinely unfamiliar tester.
Anyone with prior exposure fills gaps a true first-time visitor cannot.

Count staff queries precisely, don't estimate.
"A couple of times" and "zero times" are very different outcomes.

E-LEARNING academy.gmj.ge/std1-4-wayfinding — 30 min · complete before self-assessment

STANDARD 2

Reception & Information

MANDATORY

5 criteria

Standard 2.1 **NON-NEGOTIABLE** · *Standard 2: Reception & Information*

Patients Know Their Rights

ASSESSMENT *ASF-STD2-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

2.1
NON-NEGOTIABLE
L1

THE STANDARD

Patients Know Their Rights

A patient rights charter exists, is visibly displayed, and patients can describe it in their own words — not a document filed away that nobody references.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a patient rights charter visibly displayed in areas patients actually pass through?** *Not filed in an office — posted somewhere a patient waiting or arriving would see it.* Doc: Photo of displayed charter	YES	PARTIAL	NO
2	**Is the charter written in plain language, in the languages patients actually speak?** *A legal document patients can't parse doesn't meet this, regardless of how thorough it is.* Doc: Charter text, all language versions	YES	PARTIAL	NO
3	**Can a patient asked directly describe at least one of their rights in their own words?** *Not whether the charter exists — whether it reached them.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Display check*	Checks whether the rights charter is genuinely visible in patient-facing areas, not just technically present somewhere in the building.
ASK *Patient awareness test*	Asks a patient, unprompted, whether they know they have specific rights as a patient here, and what those are.
DOCUMENT *Language coverage check*	Reviews which languages the charter is available in against the languages the patient population actually speaks.

REFERENCES

[33] *WHO's framework for people-centred health services identifies patient awareness of their own rights as a precondition for meaningful participation in their own care, not a downstream courtesy.*

Standard 2.1 · *Standard 2: Reception & Information*
Guidance & Learning

GUIDANCE
ASF-STD2-v3.0

WHY THIS STANDARD EXISTS

A rights charter that exists only in an office drawer protects nobody. Rights only function as rights if the person they protect knows they have them, in language they actually understand.

The evidence [33]: WHO's framework for people-centred health services identifies patient awareness of their own rights as a precondition for meaningful participation in their own care, not a downstream courtesy.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The charter is visibly posted in waiting areas and patient rooms, in the languages patients speak.	✗ The charter exists only in an administrative office, never seen by patients.
✓ A patient asked directly can describe at least one specific right in their own words.	✗ Patients asked directly have no idea they have any specific rights.
✓ Staff can point to where the charter is displayed without hesitation.	✗ The charter exists in only one language in a facility serving a multilingual population.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **The charter is displayed but only in the language of the majority population.**
A meaningful minority of patients may be functionally unable to read the one version posted.

2 **The charter is posted but written in legal or clinical language patients don't parse easily.**
Technically available and practically accessible are different things.

3 **Staff know the charter exists but have never actively explained it to a patient.**
Passive availability rarely closes the awareness gap on its own.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Check current charter display locations and language coverage against actual patient-facing areas.

Week 2 Rewrite the charter in plain language if the current version is legal or clinical in tone.

Week 3 Translate into the languages your patient population actually speaks.

Ongoing Brief reception and ward staff to actively reference the charter, not just display it passively.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient directly, don't rely on staff description of the process.
Staff describing the policy and a patient's actual awareness are different things entirely.

Check language coverage against the actual patient population, not the national language alone.
A single-language charter can look complete while still failing a meaningful share of patients.

E-LEARNING academy.gmj.ge/std2-1-patient-rights — 30 min · complete before self-assessment

Standard 2.2 **CORE** · *Standard 2: Reception & Information*

Pricing Is Disclosed Before Care Begins

ASSESSMENT *ASF-STD2-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

2.2
CORE
L1

THE STANDARD

Pricing Is Disclosed Before Care Begins

Patients receive clear, honest information about the cost of services before treatment begins, in a form they can actually understand and keep.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is pricing information provided to patients before treatment begins, not only on the final invoice?** *Cost disclosure after the fact doesn't allow informed decision-making.* Doc: Pricing disclosure sample	YES	PARTIAL	NO
2	**Is pricing information given in a form the patient can keep and review, not only spoken once?** *A verbal mention easily forgotten under stress is not the same as a document the patient can refer back to.* Doc: Written estimate or pricing sheet	YES	PARTIAL	NO
3	**Can a patient describe roughly what they were told a procedure would cost, after being told?** *Tests whether the disclosure actually registered, not just whether it technically happened.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Disclosure timing review*	Reviews a sample of patient records or billing files for evidence pricing was disclosed before treatment, not only invoiced after.
OBSERVE *Written disclosure format check*	Checks whether pricing information is provided in a retainable written form, not only spoken.
ASK *Patient recall check*	Asks a recently treated patient what they recall being told about cost before their procedure.

REFERENCES

[38] *WHO's guidance on universal health coverage identifies financial transparency at the point of care as a core determinant of patients' ability to exercise informed choice, particularly in out-of-pocket payment settings.*

Standard 2.2 · *Standard 2: Reception & Information*

Guidance & Learning

GUIDANCE
ASF-STD2-v3.0

WHY THIS STANDARD EXISTS

A patient who doesn't know the cost of care until the bill arrives cannot make an informed choice about their own treatment. Financial transparency isn't a courtesy layered on top of care — for many patients, it's a precondition for consenting to it at all.

The evidence [38]: WHO's guidance on universal health coverage identifies financial transparency at the point of care as a core determinant of patients' ability to exercise informed choice, particularly in out-of-pocket payment settings.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Pricing is disclosed in writing before treatment begins, consistently.	✗ Patients learn the cost only when the final bill arrives.
✓ Patients can describe roughly what they were told a procedure would cost.	✗ Pricing is mentioned verbally once, with no written record for the patient to keep.
✓ Estimates are honest and reasonably close to final costs, with any changes explained.	✗ Patients report being surprised by charges never mentioned beforehand.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Pricing is disclosed for major procedures but not consistently for smaller add-on services.**
Ancillary charges often accumulate without the same disclosure discipline applied to the primary procedure.

2 **A written estimate is given but in language or format patients find hard to actually use.**
Technical or dense pricing sheets can technically satisfy the requirement while functionally failing patients.

3 **Disclosure happens reliably for planned admissions but less consistently for urgent or emergency care.**
Time pressure in urgent situations can compress or skip the disclosure step, precisely when patients are least able to advocate for it.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of recent patient bills against whether pricing was disclosed beforehand.

Week 2 Build a simple, clear written pricing estimate template.

Week 3 Brief admissions and reception staff to provide it consistently, including for urgent cases.

Ongoing Spot-check patient recall of pricing information periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient what they were told, not what the policy says.
The gap between policy and lived patient experience is exactly what this checks.

Check urgent or emergency admissions specifically.
Disclosure discipline most commonly erodes under time pressure.

E-LEARNING academy.gmj.ge/std2-2-pricing-disclosure — 30 min · complete before self-assessment

	Standard 2.3 NON-NEGOTIABLE · *Standard 2: Reception & Information* **Reception Desk Accessibility**	ASSESSMENT *ASF-STD2-v3.0*
CR ADAPTED	TR FULL	SM FULL / ST FULL

2.3
NON-NEGOTIABLE
L1

THE STANDARD

Reception Desk Accessibility

At least one reception or registration point is at a height a wheelchair user can approach and communicate with the receptionist at eye level — not looking up at a standard-height counter designed only for someone standing.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is at least one reception or registration point at a height a wheelchair user can comfortably use?** *Not the whole desk — at least one section genuinely usable at wheelchair height.* Doc: Photo of reception desk height	YES	PARTIAL	NO
2	**Can a wheelchair user communicate with the receptionist at eye level, not looking up at them?** *Genuine eye-level interaction, not shouting up over a counter edge.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is the lower section actually kept clear and usable, not blocked by files, equipment, or signage?** *A lower desk section that exists but is permanently cluttered doesn't meet this in practice.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Desk height check*	Physically checks reception desk height against standard wheelchair-accessible height guidelines.
OBSERVE *Clear access test*	Checks whether the lower section, if present, is genuinely clear and usable, not obstructed by clutter.
ASK *Staff awareness interview*	Asks reception staff whether they're aware of and actively use the accessible section when needed.

REFERENCES

[26] *UN CRPD, Article 9 — Accessibility (2006), which explicitly requires accessible design of service points, not only structural access to a building.*

Standard 2.3 · *Standard 2: Reception & Information*

Guidance & Learning

GUIDANCE
ASF-STD2-v3.0

WHY THIS STANDARD EXISTS

A standard-height reception desk forces a wheelchair user into a genuinely undignified position — looking up at whoever is helping them, often struggling to be seen or heard over the counter edge. This is a specific, well-observed, easily fixed gap that most facilities never think to check, because it's designed around the assumption every patient approaches standing.

The evidence [26]: UN CRPD, Article 9 — Accessibility (2006), which explicitly requires accessible design of service points, not only structural access to a building.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ At least one clearly usable, wheelchair-height reception point exists and is kept clear.	✗ The entire reception desk is standard height, with no accessible alternative.
✓ A wheelchair user can interact with the receptionist at genuine eye level.	✗ A lower section exists but is permanently covered with files, boxes, or equipment.
✓ Reception staff are aware of and actively use the accessible point without needing to be reminded.	✗ Staff are unaware an accessible point exists or don't know to direct patients there.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A lower section was built but has gradually become a storage spot for overflow items.**
Good intentions at design stage don't guarantee the space stays usable in daily practice.

2 **The accessible point exists but is positioned awkwardly, away from the main queue.**
Physical accessibility without practical, dignified positioning only partly closes the gap.

3 **New staff aren't briefed on the accessible point during their own induction.**
Awareness can quietly fade from an facility's practice if it's never actively reinforced.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Check current reception desk height against accessible design guidelines.

Week 2 If no accessible section exists, identify the lowest-cost way to add one — a lowered counter segment is often sufficient.

Week 3 Clear and designate the accessible section, briefing all reception staff on its purpose.

Ongoing Include the accessible reception point in routine facility walk-throughs to ensure it stays clear.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Physically check the height yourself, don't just ask if one exists.
A technically accessible section that's cluttered or awkwardly placed doesn't function as intended.

Ask a reception staff member to demonstrate, not just describe.
Genuine practical use versus theoretical awareness shows in how confidently they can point to it.

E-LEARNING academy.gmj.ge/std2-3-reception-accessibility — 30 min · complete before self-assessment

	Standard 2.4 **CORE** · *Standard 2: Reception & Information* **Health Information Is Genuinely Understandable, Not Just Provided**	**ASSESSMENT** *ASF-STD2-v3.0*

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

2.4
CORE
L1

THE STANDARD

Health Information Is Genuinely Understandable, Not Just Provided

Health information given to patients — about their condition, options, and next steps — is delivered in plain language and verified as actually understood, not handed over in clinical terminology and assumed to have registered.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is health information routinely delivered in plain language, avoiding unexplained medical terminology?** *Genuinely accessible language, not clinical terms used without explanation.* Doc: Patient information materials sample	YES	PARTIAL	NO
2	**Is patient understanding actively verified, such as through teach-back, not assumed from a nod?** *An active check, not passive delivery followed by an assumption it landed.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are information materials available in the languages the patient population actually needs, not just the primary local language?** *Matched to actual population need, not a single default assumption.* Doc: Language coverage of information materials	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Plain language practice check*	Reviews patient information materials and observes clinical conversations for genuine plain-language use.
OBSERVE *Understanding verification observation*	Observes whether patient understanding is actively checked, not assumed, during information delivery.
DOCUMENT *Language coverage review*	Reviews information materials against the languages the actual patient population needs.

REFERENCES

Health literacy and plain-language communication are established determinants of patient understanding and engagement in care decisions, consistently identified in patient safety literature as distinct from the simple provision of information.

Standard 2.4 · *Standard 2: Reception & Information*
Guidance & Learning

GUIDANCE
ASF-STD2-v3.0

WHY THIS STANDARD EXISTS

Providing information and a patient genuinely understanding it are two different things, and the gap between them is where informed decisions quietly fail to happen. Plain language and active verification of understanding are what actually close that gap, not the act of providing information alone.

The evidence: Health literacy and plain-language communication are established determinants of patient understanding and engagement in care decisions, consistently identified in patient safety literature as distinct from the simple provision of information.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Information is consistently delivered in genuine plain language.	✗ Information relies on unexplained clinical terminology.
✓ Patient understanding is actively verified, not assumed.	✗ Understanding is assumed from a nod, with no active verification.
✓ Materials are available in the languages the patient population actually needs.	✗ Materials exist only in the facility's default language regardless of patient population need.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Plain language is used for major decisions but reverts to clinical shorthand for routine information.**
Simplification effort often concentrates on high-stakes moments, leaving routine communication less accessible.

2 **Verification happens for complex decisions but not for everyday instructions.**
Misunderstood routine instructions still carry real risk, even if lower stakes than major decisions.

3 **Materials exist in the majority language but not the languages of smaller patient populations actually served.**
Coverage that matches the majority can still leave a meaningful minority unsupported.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current patient information materials and typical conversation practice for plain-language use.

Week 2 Train staff on teach-back or equivalent understanding-verification techniques.

Week 3 Assess language coverage against the actual patient population and address gaps.

Ongoing Spot-check patient understanding periodically across both major and routine information.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient to explain back what they were told, not whether they understood.
This tests actual comprehension rather than self-reported confidence.

Check materials for a less common language in the patient population, not just the majority one.
Coverage gaps concentrate exactly where they're least visible in a general review.

E-LEARNING academy.gmj.ge/std2-4-health-literacy — 30 min · complete before self-assessment

Standard 2.5 **CORE** · *Standard 2: Reception & Information*

Waiting and Queue Time Is Actively Managed

ASSESSMENT *ASF-STD2-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

2.5
CORE
L1

THE STANDARD

Waiting and Queue Time Is Actively Managed

Patients waiting for registration, triage, or an ambulatory appointment are managed through a defined queue system with visible, honest wait-time information — not left to wonder, unmanaged, how long they'll wait or whether they've been forgotten.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a defined queue management system for registration, triage, and ambulatory waiting, not an informal first-come approach with no structure?** *A specific, functioning system, not assumed to be self-evident from a waiting room and a door.* Doc: Queue management system description	YES	PARTIAL	NO
2	**Is honest wait-time information visible or communicated to waiting patients?** *Genuine, reasonably accurate information, not a vague reassurance or no information at all.* Doc: Wait-time communication method	YES	PARTIAL	NO
3	**Is there a mechanism to notice if a waiting patient's condition changes or worsens while they wait?** *Active monitoring of the waiting area, not only the queue order itself.* Doc: Waiting area monitoring process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Queue system observation*	Observes the actual queue management system in operation during a busy period.
OBSERVE *Wait-time communication check*	Checks whether wait-time information is genuinely visible or communicated to patients, and whether it's reasonably accurate.
ASK *Waiting area monitoring interview*	Asks staff how they would notice a waiting patient's condition changing while queued.

REFERENCES

Structured queue management and wait-time transparency are established elements of patient experience and flow-safety frameworks in ambulatory and emergency healthcare settings internationally, linked to both patient satisfaction and earlier identification of clinical deterioration during waiting periods.

Standard 2.5 · *Standard 2: Reception & Information*

Guidance & Learning

GUIDANCE
ASF-STD2-v3.0

WHY THIS STANDARD EXISTS

An unmanaged queue doesn't just create discomfort — it creates genuine uncertainty and anxiety, particularly for patients who are unwell, in pain, or unfamiliar with how the facility works, and it makes it harder for staff to notice if someone's condition is quietly worsening while they wait.

The evidence: Structured queue management and wait-time transparency are established elements of patient experience and flow-safety frameworks in ambulatory and emergency healthcare settings internationally, linked to both patient satisfaction and earlier identification of clinical deterioration during waiting periods.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A defined queue management system operates consistently, even during busy periods. ✓ Honest, reasonably accurate wait-time information is genuinely visible or communicated. ✓ Staff describe an active process for monitoring waiting patients, not just managing queue order.	✗ No defined system exists beyond an informal sense of who arrived first. ✗ No wait-time information is available, or given information is routinely inaccurate. ✗ No mechanism exists to notice a waiting patient's condition changing before they're called.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A queue system works well during normal hours but breaks down during unusually busy periods.**
The system is most needed exactly when it's under the most strain, and that's often when it's least tested.

2 **Wait-time information is displayed but isn't updated as actual conditions change, becoming inaccurate.**
Stale information can be worse than no information, since it actively misleads rather than simply being absent.

3 **Monitoring exists for the triage waiting area specifically but not for ambulatory clinic waiting rooms.**
Deterioration risk isn't confined to emergency triage waiting; ambulatory patients wait too, sometimes for extended periods.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current queue management practice, particularly during a known busy period.

Week 2 Establish or reinforce a defined queue system with visible wait-time communication.

Week 3 Build a periodic waiting-area check into staff routine to catch condition changes while patients wait.

Ongoing Review wait-time accuracy and queue system performance periodically, especially during peak periods.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe during a genuinely busy period, not a quiet one.
Queue management systems that work fine when quiet often reveal their real gaps under pressure.

Ask how long it's actually been since the waiting area was last checked for anyone whose condition may have changed.
A specific, real answer reveals whether this is genuine practice or a theoretical process.

E-LEARNING academy.gmj.ge/std2-5-queue-management — 30 min · complete before self-assessment

STANDARD 3

Environment & Shared Spaces

MANDATORY

6 criteria

Standard 3.1 **NON-NEGOTIABLE** · *Standard 3: Environment & Shared Spaces*

Water Supply Is Safe and Monitored

ASSESSMENT *ASF-STD3-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.1
NON-NEGOTIABLE
L1

THE STANDARD

Water Supply Is Safe and Monitored

Water quality is tested on a defined schedule and a contingency plan exists for interruption — not an assumption that municipal supply is automatically safe.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is water quality tested on a defined, regular schedule, with records kept?** *"It's municipal water, it's fine" is an assumption, not a verified fact.* Doc: Water testing records	YES	PARTIAL	NO
2	**Is there a documented contingency plan for water supply interruption?** *A plan written after the fact, during an actual interruption, is not a contingency plan.* Doc: Contingency plan document	YES	PARTIAL	NO
3	**Are test results reviewed and acted on, not just filed?** *A concerning result that nobody reads is no better than not testing at all.* Doc: Review and action record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Testing record review*	Reviews water testing records for consistency, frequency, and whether the schedule is actually followed.
DOCUMENT *Contingency plan check*	Reviews the contingency plan for water interruption for specificity — is there a real backup supply arrangement, not just a statement of concern.
ASK *Response protocol interview*	Asks facility management staff to describe what actually happens if a test result comes back concerning.

REFERENCES

[31] *WHO's guidelines on water, sanitation, and hygiene in health care facilities identify regular water quality testing as foundational to infection prevention, not a peripheral utilities concern.*

Standard 3.1 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE
ASF-STD3-v3.0

WHY THIS STANDARD EXISTS

Water quality failures in healthcare settings can silently undermine every other infection-control measure in the building, from hand hygiene to sterile processing. Testing and a contingency plan are what turn an assumption into a verified fact.

The evidence [31]: WHO's guidelines on water, sanitation, and hygiene in health care facilities identify regular water quality testing as foundational to infection prevention, not a peripheral utilities concern.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Water testing happens on a defined schedule with consistent, retained records.	✗ No regular testing schedule exists beyond an assumption of municipal safety.
✓ A specific, actionable contingency plan exists for supply interruption.	✗ No contingency plan exists for interruption.
✓ Concerning results trigger a known, followed response process.	✗ Test results, when they exist, are filed without review or follow-up.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Testing happens but the schedule has gaps, particularly during busy periods.**
A routine task without a strong enforcement mechanism is often the first thing skipped when short-staffed.

2 **A contingency plan exists but has never been tested or reviewed since it was written.**
An untested plan may not reflect current facility capacity or actual supplier arrangements.

3 **Results are reviewed by one person informally, with no documented follow-up process.**
Informal review without documentation makes it hard to verify the process is genuinely reliable.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current water testing frequency and records for gaps.

Week 2 Establish or reinforce a specific, written contingency plan for supply interruption.

Week 3 Define a clear, named response process for concerning test results.

Ongoing Review testing consistency and contingency plan currency on a fixed schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for actual test records, not a statement that testing happens.
Dated records are the only real evidence of a consistent schedule.

Ask what happened the last time a result was concerning, if ever.
A real example, or the honest absence of one, reveals more than a description of policy.

E-LEARNING academy.gmj.ge/std3-1-water-safety — 30 min · complete before self-assessment

	Standard 3.2 **NON-NEGOTIABLE** · *Standard 3: Environment & Shared Spaces* **Medical Equipment Is Maintained on Schedule**	**ASSESSMENT** *ASF-STD3-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.2
NON-NEGOTIABLE
L1

THE STANDARD

Medical Equipment Is Maintained on Schedule

A maintenance programme covers all clinical equipment on a defined schedule, and faulty equipment is genuinely removed from use, not kept in service pending eventual repair.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a documented maintenance schedule covering all clinical equipment?** *Not equipment maintained "as needed" or reactively — a defined, proactive schedule.* Doc: Maintenance schedule and log	YES	PARTIAL	NO
2	**Is faulty equipment actually removed from use, not kept in service while awaiting repair?** *A tag or note isn't sufficient if the equipment remains physically accessible for use.* Doc: Removal-from-service record	YES	PARTIAL	NO
3	**Is there a named person or role responsible for the maintenance programme?** *Responsibility spread across nobody in particular usually means it happens inconsistently.* Doc: Role assignment record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Maintenance schedule review*	Reviews the maintenance schedule and log for completeness across all clinical equipment, and for consistency with actual dates.
OBSERVE *Faulty equipment check*	Checks whether any equipment currently flagged as faulty is still physically accessible for use.
ASK *Responsible person interview*	Asks whoever is responsible for the maintenance programme to describe the actual process, not just the policy.

REFERENCES

Biomedical equipment maintenance frameworks consistently identify scheduled preventive maintenance, combined with clear removal-from-service protocols, as the primary control against equipment-related patient harm.

Standard 3.2 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE
ASF-STD3-v3.0

WHY THIS STANDARD EXISTS

Equipment that silently drifts out of calibration or develops an intermittent fault is often more dangerous than equipment that visibly fails, precisely because nothing signals the problem until it affects a patient. Scheduled maintenance and firm removal-from-service rules are what catch degradation before it becomes harm.

The evidence: Biomedical equipment maintenance frameworks consistently identify scheduled preventive maintenance, combined with clear removal-from-service protocols, as the primary control against equipment-related patient harm.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A comprehensive maintenance schedule covers all clinical equipment, consistently followed.	✗ Maintenance happens reactively, only after equipment visibly fails.
✓ Faulty equipment is physically removed from use immediately, not left accessible.	✗ Equipment flagged as faulty remains physically available and is sometimes used anyway.
✓ A named person owns the programme and can describe it confidently.	✗ Nobody can identify who is responsible for the maintenance programme.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A schedule exists for major equipment but not consistently for smaller or older items.**
Coverage often reflects equipment value or visibility rather than actual risk.

2 **Faulty equipment is tagged but not physically relocated away from use.**
A tag depends on every staff member noticing and respecting it every time — physical removal doesn't.

3 **Maintenance responsibility sits with someone who has since changed roles, informally.**
Ownership gaps often follow staff transitions rather than deliberate policy change.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit current equipment against the maintenance schedule for coverage gaps.

Week 2 Establish a clear, enforced process for physically removing faulty equipment from use.

Week 3 Name a specific person or role as owner of the maintenance programme.

Ongoing Review maintenance log currency against the defined schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Look for equipment that should be flagged but isn't, not just check the flagged items.
The absence of any flagged equipment across an entire facility is itself worth questioning.

Check whether tagged-faulty equipment is still physically reachable.
A tag alone doesn't prevent use if the equipment sits in its normal location.

E-LEARNING academy.gmj.ge/std3-2-equipment-maintenance — 30 min · complete before self-assessment

Standard 3.3 **CORE** · *Standard 3: Environment & Shared Spaces*

Shared Spaces Are Genuinely Clean

ASSESSMENT *ASF-STD3-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.3
CORE
L1

THE STANDARD

Shared Spaces Are Genuinely Clean

Shared clinical and waiting areas are cleaned on a documented schedule, with cleanliness verified by more than a visual check on the day of assessment.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a documented cleaning schedule for shared spaces, with records kept?** *Not a general statement that cleaning happens — a specific, dated schedule.* Doc: Cleaning schedule and log	YES	PARTIAL	NO
2	**Is cleaning verified through more than a visual check, such as a defined inspection process?** *Visual cleanliness and actual microbial cleanliness aren't the same thing.* Doc: Verification or audit record	YES	PARTIAL	NO
3	**Are high-touch surfaces specifically included in the schedule, not just visible floor and surface areas?** *Door handles, rails, and switches are easy to overlook relative to more visible surfaces.* Doc: High-touch surface schedule	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Cleaning schedule and log review*	Reviews the documented cleaning schedule against actual completion records for shared spaces.
OBSERVE *High-touch surface check*	Checks specifically whether high-touch surfaces are included in and reflected by the cleaning routine.
ASK *Verification process interview*	Asks cleaning or infection control staff to describe how cleanliness is actually verified, beyond visual inspection.

REFERENCES

Environmental cleanliness in shared healthcare spaces is a recognised contributing factor to healthcare-associated infection transmission risk, distinct from direct clinical contact precautions.

Standard 3.3 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE
ASF-STD3-v3.0

WHY THIS STANDARD EXISTS

A space that looks clean on the day of an inspection and a space that is reliably, routinely clean are not always the same thing. A documented schedule with real verification is what distinguishes routine hygiene from performance for visitors.

The evidence: Environmental cleanliness in shared healthcare spaces is a recognised contributing factor to healthcare-associated infection transmission risk, distinct from direct clinical contact precautions.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A documented, consistently followed cleaning schedule covers all shared spaces.	✗ No documented schedule exists beyond general good intentions.
✓ High-touch surfaces are specifically and routinely addressed.	✗ High-touch surfaces show visible neglect relative to more prominent areas.
✓ Cleanliness is verified through a defined process, not visual impression alone.	✗ Verification, if it exists, is undocumented and inconsistent.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A schedule exists for main patient areas but not consistently for peripheral shared spaces.**
Corridors, waiting rooms, and less-visited areas often receive less consistent attention.

2 **Cleaning happens but high-touch surfaces aren't specifically called out in the schedule.**
A general cleaning routine can miss the specific surfaces that matter most for transmission risk.

3 **Verification exists informally but isn't documented or consistently applied.**
An informal check depends entirely on who happens to be paying attention that day.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current cleaning schedules for coverage gaps, particularly high-touch surfaces.

Week 2 Add or reinforce specific high-touch surface cleaning to the documented schedule.

Week 3 Establish a simple, documented verification step beyond visual inspection.

Ongoing Audit cleaning log completeness and verification records periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check high-touch surfaces specifically, not general visible cleanliness.
Door handles, light switches, and rails reveal more about routine practice than open floor areas.

Ask for the log, not a general assurance that cleaning happens.
Dated records are the only real evidence of a consistent schedule.

E-LEARNING academy.gmj.ge/std3-3-shared-space-cleanliness — 30 min · complete before self-assessment

Standard 3.4 **NON-NEGOTIABLE** · *Standard 3: Environment & Shared Spaces*

Facility Risks Are Tracked in One Integrated Register

ASSESSMENT *ASF-STD3-v3.0*

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

3.4
NON-NEGOTIABLE
L1

THE STANDARD

Facility Risks Are Tracked in One Integrated Register

Water safety, fire safety, equipment maintenance, and other facility risks are tracked together in one reviewed risk register — not as separate, disconnected checklists that nobody views as a whole picture.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Do water safety, fire safety, and equipment maintenance data feed into one integrated risk register, not separate untracked lists?** *A single place where facility leadership can see the whole risk picture, not scattered logs nobody reviews together.* Doc: Integrated risk register document	YES	PARTIAL	NO
2	**Is the register reviewed on a defined schedule by facility leadership, not just maintained by individual department staff?** *Review at a level that can act across domains, not only within one narrow area.* Doc: Review meeting record	YES	PARTIAL	NO
3	**Does the register prioritise risks, not just list them?** *A genuine risk management tool ranks what needs attention first, rather than treating every item as equally urgent.* Doc: Risk prioritisation criteria	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Register completeness review*	Reviews the risk register for integration across water, fire, equipment, and other facility safety domains.
DOCUMENT *Review schedule check*	Checks for evidence the register is reviewed on a defined schedule at an appropriate leadership level.
ASK *Prioritisation interview*	Asks whoever owns the register to describe how risks are prioritised, not just logged.

REFERENCES

Integrated environment-of-care risk management, tying individual facility safety domains into one reviewed register, is an established approach in international facility safety frameworks specifically because siloed tracking misses compounding and cross-cutting risks.

Standard 3.4 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE
ASF-STD3-v3.0

WHY THIS STANDARD EXISTS

Individual safety checks — water testing, fire equipment, maintenance schedules — can each look fine in isolation while the facility's overall risk picture goes unexamined. An integrated register is what lets leadership see the whole picture at once, and catch a combination of smaller issues that individually seem manageable but together represent a real, compounding risk.

The evidence: Integrated environment-of-care risk management, tying individual facility safety domains into one reviewed register, is an established approach in international facility safety frameworks specifically because siloed tracking misses compounding and cross-cutting risks.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Facility risks across all domains feed into one integrated, actively maintained register.	✗ Water safety, fire safety, and maintenance records exist as entirely separate, unconnected logs.
✓ The register is reviewed on a defined schedule by facility leadership.	✗ No defined review schedule exists at a leadership level.
✓ Risks are prioritised, with the highest-risk items visibly addressed first.	✗ All items are treated with equal, undifferentiated priority, or not prioritised at all.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Individual domain tracking is strong, but nothing yet integrates them into one register.**
Good individual records don't automatically produce a combined view without deliberate effort to build one.

2 **A register exists but review happens irregularly rather than on a fixed schedule.**
An ad hoc review pattern risks the register becoming stale between infrequent looks.

3 **The register lists risks but doesn't clearly rank which need attention first.**
A list without prioritisation provides less genuine risk management value than one that does.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Inventory current facility safety tracking across water, fire, equipment, and other domains.

Week 2 Consolidate these into one integrated risk register.

Week 3 Establish a defined review schedule at an appropriate leadership level.

Ongoing Review and reprioritise the register on the defined schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the register itself, not descriptions of individual domain tracking.
The integration itself is what this standard checks, not whether individual pieces exist.

Ask who reviews it and how often, specifically.
A specific, named review process is the real evidence of active use, not passive existence.

E-LEARNING academy.gmj.ge/std3-4-risk-register — 30 min · complete before self-assessment

Standard 3.5 **CORE** · *Standard 3: Environment & Shared Spaces*

An Environmental Sustainability Programme Is Genuinely Active

ASSESSMENT *ASF-STD3-v3.0*

CR N/A	TR ADAPTED	SM ADAPTED	ST FULL

3.5
CORE
L1

THE STANDARD

An Environmental Sustainability Programme Is Genuinely Active

The facility has a specific, documented environmental sustainability programme — covering energy use, waste reduction, and resource consumption — with real, tracked progress, not a general statement of environmental awareness with no measurable action behind it.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific, written sustainability programme covering energy, waste, and resource use?** *A specific, documented programme, not a general statement of environmental values.* Doc: Sustainability programme document	YES	PARTIAL	NO
2	**Is progress tracked against defined, measurable targets?** *Real, trackable metrics, not an assumption that good intentions are sufficient.* Doc: Progress tracking data	YES	PARTIAL	NO
3	**Is there a named person or team responsible for the programme?** *Specific ownership, not diffuse responsibility that belongs to nobody in particular.* Doc: Role assignment record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Programme document review*	Reviews the sustainability programme for specificity across energy, waste, and resource use.
DOCUMENT *Progress tracking check*	Reviews tracked data against defined targets for genuine, measurable progress.
ASK *Responsible person interview*	Asks whoever owns the programme to describe current initiatives and real progress specifically.

REFERENCES

Environmental sustainability and climate resilience programmes are an emerging but increasingly established requirement across international healthcare accreditation frameworks, reflecting both direct environmental impact and operational resilience considerations.

Standard 3.5 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE
ASF-STD3-v3.0

WHY THIS STANDARD EXISTS

Healthcare facilities have a substantial environmental footprint, and increasingly face both resource-cost pressure and climate-related operational risk. A genuine sustainability programme is not a public-relations gesture — it's a practical response to real cost and resilience pressures the facility already faces.

The evidence: Environmental sustainability and climate resilience programmes are an emerging but increasingly established requirement across international healthcare accreditation frameworks, reflecting both direct environmental impact and operational resilience considerations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, written programme covers energy, waste, and resource use with real detail.	✗ No specific programme exists beyond a general environmental values statement.
✓ Progress is tracked against measurable targets, with genuine data.	✗ No tracking exists to demonstrate any measurable progress.
✓ A named person or team owns the programme and can describe real, current initiatives.	✗ Nobody is specifically responsible for the programme.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A programme exists and covers energy well but waste and water use are addressed less specifically.**
Sustainability programmes often start with the most visible or easily measured area and expand unevenly.

2 **Targets exist but tracking data hasn't been consistently collected to demonstrate progress against them.**
A target without consistent measurement can't actually demonstrate whether progress is happening.

3 **The programme is genuinely active but was never formally documented in writing.**
Real activity that isn't documented is harder to verify, sustain through staff changes, or build on.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Document current sustainability activities, even if informal, across energy, waste, and resource use.

Week 2 Set specific, measurable targets for the areas with the least current attention.

Week 3 Establish a tracking process and name a specific owner for the programme.

Ongoing Review progress against targets on a fixed schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for actual tracked data, not a description of good intentions.
Measurable progress is the real evidence of a genuine, not aspirational, programme.

Ask about waste and water specifically, not just energy.
Programmes often develop unevenly, and less-visible areas can lag behind.

E-LEARNING academy.gmj.ge/std3-5-sustainability — 30 min · complete before self-assessment

Standard 3.6 **NON-NEGOTIABLE** · *Standard 3: Environment & Shared Spaces*

Facility Signage Is Complete, Not Just Present at Reception

ASSESSMENT *ASF-STD3-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.6
NON-NEGOTIABLE
L1

THE STANDARD

Facility Signage Is Complete, Not Just Present at Reception

Evacuation routes, emergency exits, restrooms, and procedure or department doors are clearly and consistently signed throughout the facility — not only the entrance and reception area covered under wayfinding, and not assumed adequately covered by evacuation drills alone.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are evacuation routes and emergency exits clearly signed throughout the facility, not only near the main entrance?** *Comprehensive coverage — deep corridors, upper floors, less-trafficked areas — not concentrated near reception.* Doc: Photo audit of evacuation signage throughout the facility	YES	PARTIAL	NO
2	**Are restrooms and procedure or department doors clearly and consistently labelled?** *Consistent labelling convention throughout, not signage that varies by department or era of installation.* Doc: Signage consistency audit	YES	PARTIAL	NO
3	**Is signage periodically checked for damage, obstruction, or fading, not installed once and assumed permanent?** *Signage degrades over time and needs the same ongoing attention as any other safety measure.* Doc: Signage inspection schedule and record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Comprehensive signage walk-through*	Walks the full facility, including deep corridors and upper floors, checking evacuation route and exit signage completeness.
OBSERVE *Labelling consistency check*	Checks restroom and department door labelling for consistency across different areas of the facility.
DOCUMENT *Inspection schedule review*	Reviews the signage inspection schedule and recent inspection records for damage, obstruction, or fading.

REFERENCES

Facility signage completeness, including evacuation route marking throughout the building, is a distinct requirement from initial wayfinding and evacuation drill practice in international healthcare facility safety frameworks, reflecting that a drill tests staff response while signage protects anyone in the building at any time.

Standard 3.6 · *Standard 3: Environment & Shared Spaces*

Guidance & Learning

GUIDANCE
ASF-STD3-v3.0

WHY THIS STANDARD EXISTS

A facility can have excellent wayfinding to reception and a well-rehearsed evacuation drill, and still have corridors deep in the building where a patient, visitor, or even staff member genuinely cannot find the nearest exit, a bathroom, or the correct department door without asking. Signage has to be complete throughout the building, not concentrated only where a first-time visitor's initial journey was mapped.

The evidence: Facility signage completeness, including evacuation route marking throughout the building, is a distinct requirement from initial wayfinding and evacuation drill practice in international healthcare facility safety frameworks, reflecting that a drill tests staff response while signage protects anyone in the building at any time.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Evacuation routes and exits are clearly signed throughout the entire facility, not just near the entrance.	✗ Evacuation signage is strong near the entrance but sparse or absent in deeper parts of the building.
✓ Restroom and department labelling is consistent throughout, using the same clear convention.	✗ Labelling conventions vary noticeably between departments or building sections.
✓ Signage is periodically inspected and maintained, with a documented schedule.	✗ Signage is installed once with no ongoing inspection, and visible damage or fading goes unaddressed.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Signage is comprehensive on the ground floor but thins out on upper floors or in older sections of the building.**
Signage completeness often reflects when different parts of a building were last renovated, not a deliberate consistent standard.

2 **Evacuation routes are signed but restroom and department labelling wasn't part of the same signage review.**
A facility can focus on life-safety signage specifically and overlook general wayfinding signage as a separate, equally needed category.

3 **An inspection schedule exists but hasn't caught a specific known issue, like a sign obscured by newly placed equipment.**
Even a good schedule can be undermined by changes to the physical space between inspections.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Walk the entire facility, not just entrance areas, and log every signage gap found.

Week 2 Prioritise and address evacuation route and exit signage gaps first.

Week 3 Standardise restroom and department labelling conventions throughout the facility.

Ongoing Establish a periodic signage inspection schedule covering the whole building, not just high-traffic areas.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Walk deep into the building, not just the entrance and main corridors.
Signage gaps concentrate exactly where a typical assessment visit might not naturally go.

Check for physical obstruction of existing signage, not just its initial presence.
A sign that exists but is blocked by stored equipment provides no real protection.

E-LEARNING academy.gmj.ge/std3-6-facility-signage — 30 min · complete before self-assessment

STANDARD 4

Care & Treatment

MANDATORY

37 criteria

	Standard 4.1 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Consent Is Real, Not a Signature**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.1
NON-NEGOTIABLE
L1

THE STANDARD

Consent Is Real, Not a Signature

Informed consent explains risks, benefits, and alternatives before every significant procedure — a genuine conversation the patient can describe back, not a form signed on the way into theatre.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Can a patient who signed a consent form in the last month describe, in their own words, what the procedure involves?** *Not whether they signed — whether they understood.* Doc: Patient interview, or documented consent conversation notes	YES	PARTIAL	NO
2	**Are risks, benefits, and at least one alternative documented as discussed, not just the procedure name?** *A generic form listing the procedure only, with no discussion recorded, does not meet this.* Doc: Consent form plus conversation record	YES	PARTIAL	NO
3	**Is consent taken far enough in advance that a patient could realistically change their mind?** *Consent obtained on the trolley outside theatre is not meaningfully free.* Doc: Timing record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Patient understanding check*	Asks a recently consented patient, separately from staff, to describe the procedure and its main risk in their own words.
DOCUMENT *Consent record review*	Reviews a sample of consent forms for evidence of a real discussion — risks, alternatives, and questions — not just a signature line.
OBSERVE *Timing check*	Checks when consent is typically obtained relative to the procedure, looking for last-minute, pressured timing as a pattern.

REFERENCES

[40] *WHO's Guidelines for Safe Surgery identify complete, understood consent as a precondition of the pre-induction checklist step, not a separate administrative task.*

Standard 4.1 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A signature proves paperwork happened, not that the patient understood what they agreed to. Consent taken as a formality rather than a conversation fails patients precisely when the stakes are highest — before something irreversible.

The evidence [40]: WHO's Guidelines for Safe Surgery identify complete, understood consent as a precondition of the pre-induction checklist step, not a separate administrative task.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A patient describes their procedure and its main risk accurately, in their own words.	✗ A patient can only repeat the procedure's name, with no understanding of risk.
✓ Consent forms show alternatives were discussed, not just the chosen procedure listed.	✗ Consent forms are identical boilerplate with no evidence of individualised discussion.
✓ Consent is routinely obtained with enough lead time to allow real reconsideration.	✗ Consent is obtained minutes before the procedure, as a matter of routine.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Consent is taken by whoever is available, not the person actually performing the procedure.**
A junior staff member relaying information secondhand often can't answer real questions.

2 **The form is thorough but nobody checks the patient actually understood it.**
Literacy, language, and anxiety all affect comprehension in ways a signature can't reveal.

3 **Consent happens early for the form, but the real conversation happens later, unrecorded.**
The documented timing and the actual informed moment can diverge without anyone noticing.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of recent consent forms for evidence of real discussion versus boilerplate.

Week 2 Brief staff who take consent on checking understanding directly — ask the patient to explain it back.

Week 3 Build consent timing into the pre-procedure schedule, not left to whenever there's a spare moment.

Ongoing Spot-check patient understanding periodically, not only when something goes wrong.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the patient before looking at the form.
Their own account, unprompted by the paperwork, reveals what they actually retained.

Check who is named as taking consent versus who actually performs the procedure.
A mismatch is a common, quiet failure point.

E-LEARNING academy.gmj.ge/std4-1-consent — 30 min · complete before self-assessment

	Standard 4.2 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Staff Credentials Are Checked and Current**	**ASSESSMENT** *ASF-STD4-v3.0*
CR ADAPTED	**TR** FULL	**SM** FULL	**ST** FULL

4.2
NON-NEGOTIABLE
L1

THE STANDARD

Staff Credentials Are Checked and Current

Every clinical staff member's qualifications are verified and on file — checked directly with the issuing or licensing body, not taken on the applicant's word.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every clinical staff member's licence or qualification verified directly with the issuing body?** *A photocopied certificate on file is not verification — contacting the issuer is.* Doc: Verification record per staff member	YES	PARTIAL	NO
2	**Are credentials rechecked on renewal, not just at hiring?** *A licence can lapse or be revoked after hiring without anyone noticing if it's never rechecked.* Doc: Renewal tracking log	YES	PARTIAL	NO
3	**Is there a named person responsible for credential tracking, not an informal arrangement?** *Responsibility spread across nobody in particular usually means it happens to nobody in particular.* Doc: Role assignment record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Verification record check*	Selects a sample of staff files and checks for evidence of direct verification with the issuing body, not just a filed copy.
ASK *Responsible person interview*	Asks whoever is named as responsible for credentialing to describe the actual verification process, not the policy on paper.
OBSERVE *Renewal tracking check*	Checks whether any staff credential is currently overdue for renewal without a tracked follow-up.

REFERENCES

Credential verification failures are a recurring, preventable category in patient safety literature — the checkable fact is whether verification happened directly with the issuing body, not whether a certificate was filed.

Standard 4.2 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A credential nobody verified is not a credential — it's a claim. Direct verification with the licensing body is the only check that cannot be forged by the applicant, which is precisely why it's the one step organisations are most tempted to skip when hiring quickly.

The evidence: Credential verification failures are a recurring, preventable category in patient safety literature — the checkable fact is whether verification happened directly with the issuing body, not whether a certificate was filed.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A clear, current verification record exists for each clinical staff member, checked directly with the issuer.	✗ Staff files contain photocopied certificates with no evidence anyone contacted the issuing body.
✓ A named person owns credential tracking and can describe the process confidently.	✗ Nobody can say who is responsible for credentialing when asked directly.
✓ Renewals are tracked proactively, not discovered as overdue by accident.	✗ A lapsed credential is discovered only when this question is asked, not through routine tracking.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 Verification happened once, at hiring, years ago, with no renewal check since.
A licence current at hiring says nothing about its status now.

2 Responsibility for credentialing sits with someone who has since left, informally.
Nobody deliberately dropped it — it just had no clear owner after a staff change.

3 Verification happens for doctors but not consistently for nurses or allied staff.
A common, unstated hierarchy of rigor that isn't a deliberate policy, just a habit.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit current staff files for evidence of direct verification versus filed copies.

Week 2 Contact issuing bodies directly for any credential not yet verified this way.

Week 3 Name one person as owner of ongoing credential tracking, with it in their actual job description.

Ongoing Build renewal dates into a simple calendar or tracker, checked monthly.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the verification record, not the certificate.
A certificate proves the applicant had a document; a verification record proves someone checked it was real.

Pick a staff member at random, not one the facility suggests.
A prepared example proves less than a genuinely random check.

E-LEARNING academy.gmj.ge/std4-2-credentials — 30 min · complete before self-assessment

	Standard 4.3 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **New Staff Are Properly Onboarded**	ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.3
NON-NEGOTIABLE
L1

THE STANDARD

New Staff Are Properly Onboarded

Mandatory induction covers safety essentials before independent work begins — a defined, checklist-based process, not learning by observation over the first few unsupervised weeks.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a documented induction checklist covering safety essentials before independent work?** *Not a general welcome session — specific safety content, checked off item by item.* Doc: Induction checklist, completed and signed	YES	PARTIAL	NO
2	**Does induction happen before independent work begins, not alongside it?** *Learning safety essentials while already working unsupervised defeats the purpose.* Doc: Timing record against start date	YES	PARTIAL	NO
3	**Can a recently hired staff member describe what their induction actually covered?** *A completed checklist with no real retention suggests a formality, not real training.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Induction checklist review*	Reviews the induction checklist for specific, checkable safety content, not generic orientation topics.
ASK *New staff interview*	Asks a recently hired staff member what their induction actually covered, independently of the checklist.
OBSERVE *Timing verification*	Checks the gap between hire date and induction completion against the date independent work began.

REFERENCES

Induction and orientation quality is repeatedly identified in patient safety literature as a modifiable factor in early-tenure adverse events, distinct from formal qualification.

Standard 4.3 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

The gap between hiring and genuine competence is exactly when preventable errors cluster. A new staff member left to infer safety practices by watching colleagues inherits whatever habits — good or bad — happen to be around them.

The evidence: Induction and orientation quality is repeatedly identified in patient safety literature as a modifiable factor in early-tenure adverse events, distinct from formal qualification.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, checklist-based induction is completed before independent work begins.	✗ Induction is a general welcome with no specific safety checklist.
✓ A new staff member can describe real safety content from their induction, not just that it happened.	✗ A new staff member cannot recall any specific safety content from their induction.
✓ Induction timing consistently precedes unsupervised work, verified by record.	✗ Independent work begins before induction is documented as complete.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 A checklist exists but is completed retroactively, after work has already begun.
The paperwork catches up eventually; the actual unsupervised gap already happened.

2 Induction covers policy but not the specific hazards of this facility.
Generic safety content misses the facility-specific risks a new hire actually needs to know.

3 Senior staff are exempted from induction because they're "experienced."
Experience elsewhere doesn't cover this facility's specific layout, equipment, and protocols.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Draft a specific, checklist-based induction covering this facility's actual safety essentials.

Week 2 Assign a named person to deliver and sign off induction for every new hire, no exceptions.

Week 3 Test the induction on a current staff member — can they recall the content afterward?

Ongoing Review and update the induction checklist whenever a new hazard or protocol change occurs.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the newest hire, not a convenient example.
The most recent hire's experience is the freshest, most accurate test of current practice.

Ask what they'd do in a specific scenario, not just what the checklist covered.
Retained understanding shows in application, not recitation.

E-LEARNING academy.gmj.ge/std4-3-onboarding — 30 min · complete before self-assessment

Standard 4.4 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Staffing Actually Matches Patient Need

ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.4
NON-NEGOTIABLE
L1

THE STANDARD

Staffing Actually Matches Patient Need

Staffing levels and skill mix are documented against real patient volume and acuity — a calculation grounded in actual demand, not a fixed roster set once and never revisited.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is staffing calculated against actual, current patient volume and acuity, not a fixed historical roster?** *A roster set years ago and never revisited doesn't reflect today's real demand.* Doc: Staffing methodology document	YES	PARTIAL	NO
2	**Is there a defined process for escalating when staffing falls short of documented need?** *Recognising a shortfall is only useful if something happens as a result.* Doc: Escalation protocol	YES	PARTIAL	NO
3	**Can staff describe what happens when they're short-staffed, beyond "we manage"?** *A vague answer usually means there's no real process, just accumulated coping.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Staffing methodology review*	Reviews how staffing levels are calculated and whether the calculation reflects actual, current patient volume and acuity.
ASK *Front-line escalation interview*	Asks front-line staff what actually happens when a shift is short-staffed relative to patient need.
OBSERVE *Roster-to-census comparison*	Compares recent rosters against actual patient census and acuity data to check for a real, tracked relationship.

REFERENCES

[4] *Aiken et al.'s research on nurse staffing ratios and patient outcomes is among the most replicated findings in health services research, linking staffing levels directly to mortality and complication rates.*

Standard 4.4 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Understaffing relative to real patient acuity is one of the most consistently documented drivers of preventable harm in hospital care. A roster that looked adequate when it was written can become dangerously thin as patient volume or complexity shifts, if nobody is tracking the relationship between the two.

The evidence [4]: Aiken et al.'s research on nurse staffing ratios and patient outcomes is among the most replicated findings in health services research, linking staffing levels directly to mortality and complication rates.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staffing is calculated against documented, current patient volume and acuity data.	✗ The roster hasn't been recalculated against real patient data in years.
✓ A clear, used escalation process exists for staffing shortfalls.	✗ No escalation process exists — shortfalls are absorbed silently.
✓ Staff describe a real, specific process for short-staffed situations, not improvisation.	✗ Staff describe managing shortfalls through informal overtime with no tracked pattern.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Staffing was calculated correctly once but never revisited as patient volume changed.**
A methodology that was sound at inception can become stale without anyone deciding to abandon it.

2 **An escalation process exists on paper but staff don't know it or use it.**
A policy nobody uses functions identically to no policy at all.

3 **Acuity is tracked for some patients but not systematically across the whole unit.**
Partial acuity tracking gives a partial, potentially misleading picture of real need.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Compare current rosters against actual recent patient volume and acuity data.

Week 2 Identify the gap, if any, between documented staffing methodology and real practice.

Week 3 Build or revise a simple, usable escalation process for shortfalls, and brief all staff on it.

Ongoing Revisit the staffing calculation on a fixed schedule, not only when a crisis forces the question.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff directly, not management, what happens when short-staffed.
Management's description of the escalation process and staff's lived experience of it can diverge significantly.

Look at a real shift's data, not an idealised average.
Averages can hide genuinely dangerous individual shifts.

E-LEARNING academy.gmj.ge/std4-4-staffing — 30 min · complete before self-assessment

	Standard 4.5 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **Hand Hygiene Actually Happens**	ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.5
NON-NEGOTIABLE
L1

THE STANDARD

Hand Hygiene Actually Happens

Hand hygiene stations are present at the point of care and staff use them — genuinely, observably, not only when being watched.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are hand hygiene stations physically present at the actual point of care, not just at ward entrances?** *A station at the entrance to a ward doesn't help at the bedside where contact actually happens.* Doc: Photo audit of station placement	YES	PARTIAL	NO
2	**Is compliance measured through genuine, unannounced observation, not self-report?** *Staff self-report on hand hygiene is notoriously unreliable — this needs real observation.* Doc: Unannounced observation audit data	YES	PARTIAL	NO
3	**Is there a visible difference in supply availability between announced and unannounced checks?** *Stations mysteriously well-stocked only during scheduled inspections is a specific, real failure pattern.* Doc: Supply log across different dates	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Point-of-care station check*	Physically verifies hand hygiene stations exist at the actual point of care, not only at ward entrances.
OBSERVE *Unannounced compliance observation*	Conducts genuine, unannounced observation of hand hygiene practice at the WHO's Five Moments, without alerting staff in advance.
DOCUMENT *Supply consistency check*	Compares supply and stocking records across announced and unannounced dates for evidence of "inspection-only" stocking.

REFERENCES

[41] *WHO's Guidelines on Hand Hygiene in Health Care (2009) established the "Five Moments for Hand Hygiene" framework, now the global reference standard, with compliance directly linked to reduced healthcare-associated infection rates.*

Standard 4.5 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

This is the single cheapest, highest-impact intervention in the entire standard, and also one of the easiest to fake for an inspection. The gap between hand hygiene compliance when observed and when not observed is one of the most consistently documented phenomena in infection control.

The evidence [41]: WHO's Guidelines on Hand Hygiene in Health Care (2009) established the "Five Moments for Hand Hygiene" framework, now the global reference standard, with compliance directly linked to reduced healthcare-associated infection rates.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Hand hygiene stations are present exactly where care happens, fully stocked, consistently.	✗ Stations exist only at ward entrances, far from where actual patient contact happens.
✓ Unannounced observation shows genuine compliance at key moments, not just when watched.	✗ Compliance visibly drops the moment staff believe they're unobserved.
✓ Supply levels are consistent regardless of whether a visit is scheduled or unannounced.	✗ Stations are conspicuously restocked only ahead of scheduled inspections.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Stations exist everywhere but are frequently empty between restocking cycles.**
Infrastructure without reliable maintenance produces the same gap as no infrastructure.

2 **Compliance is genuinely good for some of the Five Moments but not others.**
Before touching a patient is often well internalised; after touching surroundings near a patient often is not.

3 **New staff comply well immediately after induction, then drift over time.**
Initial training works; nothing reinforces it afterward.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Map actual point-of-care locations against current hand hygiene station placement, and identify gaps.

Week 2 Fix placement gaps and establish a restocking schedule with a named owner.

Week 3 Conduct a genuine, unannounced baseline observation audit using the WHO Five Moments framework.

Ongoing Repeat unannounced audits periodically — announced-only auditing measures compliance theatre, not compliance.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Never announce the observation in advance, even implicitly.
Staff behaviour changes measurably the moment they suspect they're being watched for this specific thing.

Check supply logs across multiple dates, not just the visit day.
A single well-stocked day proves nothing about routine practice.

E-LEARNING academy.gmj.ge/std4-5-hand-hygiene — 30 min · complete before self-assessment

	Standard 4.6 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Protective Equipment Is Actually Available**	**ASSESSMENT** *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.6
NON-NEGOTIABLE
L1

THE STANDARD

Protective Equipment Is Actually Available

PPE is accessible at the point of use, not stored in a locked room or a location that adds friction between the need and the use.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is PPE physically accessible at the point of use, without requiring a key or a walk to another area?** *Locked storage or distant supply points reduce actual use regardless of stock levels.* Doc: Photo audit of PPE accessibility	YES	PARTIAL	NO
2	**Is appropriate PPE available for the specific transmission risk of each area, not a generic kit everywhere?** *A one-size-fits-all approach often means the wrong equipment is available where a specific risk exists.* Doc: PPE type mapping by area	YES	PARTIAL	NO
3	**Is stock monitored so that PPE doesn't run out mid-shift?** *A stockout discovered mid-procedure is a preventable failure, not a supply chain inevitability.* Doc: Stock monitoring log	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Point-of-use accessibility check*	Checks whether PPE is genuinely accessible at the point of use without added friction — locked doors, distant storage.
OBSERVE *Area-appropriate stock check*	Verifies the PPE available in each area matches the actual transmission risk of that area, not a generic standard kit.
DOCUMENT *Stockout history review*	Reviews stock monitoring records for evidence of past stockouts and whether any led to a documented response.

REFERENCES

[35] *Standard and transmission-based precautions frameworks, including WHO infection prevention guidance, identify point-of-use accessibility as a determinant of actual PPE use, independent of stock levels.*

Standard 4.6 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

PPE that exists in inventory but isn't accessible at the moment of need functions identically to PPE that doesn't exist. Distance and friction — a locked cupboard, a walk to another area — are enough to defeat compliance even among staff who genuinely intend to use it.

The evidence [35]: Standard and transmission-based precautions frameworks, including WHO infection prevention guidance, identify point-of-use accessibility as a determinant of actual PPE use, independent of stock levels.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ PPE is available exactly where needed, with no locks or distance barriers to access.	✗ PPE is stored in a locked area requiring a key held by one person, often unavailable.
✓ PPE type matches the specific risk profile of each area.	✗ The same generic PPE kit is provided everywhere regardless of actual risk.
✓ Stock monitoring prevents mid-shift stockouts, with a clear resupply process.	✗ Staff report having run out of a specific item mid-shift with no immediate resupply.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **PPE is accessible during the day shift but locked overnight for security reasons.**
A security decision made independently of infection control creates a genuine access gap at specific times.

2 **Stock exists in the building but not distributed to where it's actually used.**
Central storage without point-of-use distribution reproduces the accessibility problem.

3 **Reordering happens reactively, after a stockout, rather than on a proactive schedule.**
The system works until it doesn't, with no buffer for unexpected demand.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Map every point of use against current PPE storage locations and identify friction points.

Week 2 Relocate or duplicate PPE stock to eliminate locks and distance barriers at point of use.

Week 3 Match PPE type to the actual risk profile of each specific area.

Ongoing Move to proactive, scheduled reordering rather than reactive restocking after a shortage.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Try to access PPE yourself, at the point of use, without staff assistance.
Friction that staff have normalised through habit is often invisible until an outsider tries it.

Ask about overnight or weekend access specifically.
Accessibility during a scheduled daytime visit doesn't prove accessibility at other times.

E-LEARNING academy.gmj.ge/std4-6-ppe — 30 min · complete before self-assessment

Standard 4.7 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Sharps and Waste Are Handled Safely

ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.7
NON-NEGOTIABLE
L1

THE STANDARD

Sharps and Waste Are Handled Safely

Clinical waste and sharps are segregated and disposed of safely at the point of use, with containers appropriately placed rather than requiring staff to carry hazardous material any distance.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are sharps containers available immediately at the point of use, not requiring staff to walk with an exposed sharp?** *Any distance travelled with an uncontained sharp is unnecessary risk.* Doc: Photo audit of container placement	YES	PARTIAL	NO
2	**Are containers replaced before they reach unsafe fill levels, not left to overflow?** *An overfilled container is a direct, preventable injury risk.* Doc: Replacement schedule and fill-level checks	YES	PARTIAL	NO
3	**Is clinical waste segregated correctly at the point of disposal, not sorted later?** *Correct sorting after the fact requires someone to handle already-contaminated mixed waste.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Container placement check*	Verifies sharps containers are available at the actual point of use across multiple clinical areas, not centrally located.
OBSERVE *Fill-level check*	Checks current fill levels of sharps containers in use against the safe-fill line.
DOCUMENT *Injury and near-miss log review*	Reviews any sharps injury or near-miss reports for patterns related to disposal access or timing.

REFERENCES

[39] *WHO's guidance on safe injection practices and healthcare waste management identifies point-of-use sharps disposal as a core preventable-injury control measure, not an optional refinement.*

Standard 4.7 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Sharps injuries overwhelmingly occur during the gap between use and disposal, not during the clinical act itself. Correct segregation and immediately available disposal at the point of use closes that gap; a distant or absent disposal point reopens it every single time.

The evidence [39]: WHO's guidance on safe injection practices and healthcare waste management identifies point-of-use sharps disposal as a core preventable-injury control measure, not an optional refinement.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Sharps containers are present at every point of use, correctly placed and never requiring transport of an uncontained sharp. ✓ Containers are consistently replaced before reaching unsafe fill levels. ✓ Waste segregation happens correctly at the point of disposal, not sorted afterward.	✗ Staff routinely carry used sharps to a distant disposal point. ✗ Containers are found filled well past the safe-fill line. ✗ Mixed waste requires manual re-sorting after disposal, exposing staff to already-contaminated material.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Containers are correctly placed in main wards but missing in smaller or newer clinical areas.**
Coverage often reflects when an area was last reviewed, not deliberate risk assessment.

2 **Replacement happens on a fixed schedule that doesn't account for high-volume days.**
A calendar-based schedule can lag behind actual usage on busy days.

3 **Staff know the correct segregation rules but shortcuts happen under time pressure.**
Knowledge exists; the physical setup doesn't always make the correct choice the easy choice.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit every clinical area for sharps container placement relative to actual point of use.

Week 2 Add or relocate containers to close any gaps found.

Week 3 Move from calendar-based to fill-level-triggered replacement where volume is unpredictable.

Ongoing Review any sharps injury or near-miss report specifically for a disposal-access root cause.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check fill levels directly, don't rely on staff assurance.
A container reported as "fine" and a container actually below the safe-fill line are not always the same thing.

Look in smaller, less-visited clinical areas, not just main wards.
Coverage gaps concentrate in spaces reviewed less often.

E-LEARNING academy.gmj.ge/std4-7-sharps-waste — 30 min · complete before self-assessment

Standard 4.8 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Every Patient Gets a Real Assessment

ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.8
NON-NEGOTIABLE
L1

THE STANDARD

Every Patient Gets a Real Assessment

A structured clinical assessment happens on admission — a genuine evaluation using a defined process, not a chart entry completed to satisfy documentation requirements.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a structured assessment tool used on admission, not a free-text chart entry alone?** *A structured tool ensures systematic coverage regardless of who is completing it or how busy they are.* Doc: Assessment tool and completed sample	YES	PARTIAL	NO
2	**Does the assessment happen within a defined timeframe of admission, not "eventually"?** *An assessment completed a day late has already missed its window to catch early risk.* Doc: Timing record against admission time	YES	PARTIAL	NO
3	**Is the assessment specific to the patient, or does it show signs of being copied from a previous entry?** *Identical wording across different patients' assessments signals a formality, not a real evaluation.* Doc: Sample comparison across patients	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Assessment tool review*	Reviews the structured assessment tool used and checks a sample of completed assessments for genuine, patient-specific content.
OBSERVE *Timing compliance check*	Checks the gap between admission time and assessment completion across a sample of recent admissions.
ASK *Clinician interview*	Asks the clinician who completed a specific assessment to explain their reasoning for a particular finding, testing genuine engagement versus rote completion.

REFERENCES

Structured admission assessment is a foundational element of clinical governance frameworks across major health systems, directly linked to earlier detection of deterioration risk.

Standard 4.8 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

An assessment exists to catch what a cursory look would miss. A structured process forces systematic coverage; an unstructured one depends entirely on the individual clinician's memory and attention on a given day, which varies.

The evidence: Structured admission assessment is a foundational element of clinical governance frameworks across major health systems, directly linked to earlier detection of deterioration risk.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured assessment tool is used consistently, completed within a defined timeframe.	✗ Assessment entries are free text only, with no structured tool in use.
✓ Assessments show patient-specific findings and reasoning, not templated language.	✗ Assessments are frequently completed well outside any defined timeframe.
✓ Clinicians can explain their reasoning behind specific findings when asked.	✗ Multiple patients' assessments show identical or near-identical wording.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 A structured tool exists but sections are routinely left blank under time pressure.
Partial completion under pressure often defaults to skipping the sections that take longest to think through properly.

2 Assessment happens on time for planned admissions but lags for unplanned or emergency ones.
The busiest, highest-risk admissions are often exactly where the process breaks down first.

3 Senior clinicians complete genuine assessments; junior staff sometimes copy forward.
Time pressure and confidence gaps affect different staff differently.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of recent assessments for genuine, patient-specific content versus templated language.

Week 2 Set and communicate a clear timeframe for assessment completion after admission.

Week 3 Brief clinical staff specifically on the risk of copy-forward documentation.

Ongoing Spot-check assessment quality periodically, particularly for unplanned admissions.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Compare assessments across different patients, not just check they exist.
Identical wording across patients is the clearest possible sign of a copy-forward habit.

Ask the clinician to explain one specific finding, not to summarise the whole assessment.
Specific questions reveal genuine engagement in a way general ones don't.

E-LEARNING academy.gmj.ge/std4-8-assessment — 30 min · complete before self-assessment

	Standard 4.9 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **There's an Actual Care Plan**	ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.9
NON-NEGOTIABLE
L1

THE STANDARD

There's an Actual Care Plan

A documented, individualised care plan guides treatment — built from the patient's specific assessment, not a generic template applied regardless of their particular situation.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a documented care plan specific to this patient's assessment findings, not a generic template?** *A plan that could apply to any patient with a similar diagnosis, unchanged, suggests it wasn't individualised.* Doc: Care plan sample	YES	PARTIAL	NO
2	**Does the care plan get updated as the patient's condition changes, not written once and left static?** *A care plan that never changes despite documented changes in condition has stopped functioning as a plan.* Doc: Care plan revision history	YES	PARTIAL	NO
3	**Can a staff member taking over a shift find and understand the current care plan quickly?** *A plan that's hard to locate or interpret at handover fails at the exact moment it matters most.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Care plan individualisation check*	Compares care plans across patients with similar diagnoses to check for genuine individualisation versus templated content.
DOCUMENT *Revision history review*	Checks whether care plans are updated in response to documented changes in patient condition.
ASK *Handover staff interview*	Asks a staff member who recently took over a shift how quickly and clearly they located and understood the current care plan.

REFERENCES

Individualised, documented care planning is consistently associated with improved continuity of care across shift changes in health services literature, distinct from assessment quality alone.

Standard 4.9 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A care plan that exists only in a clinician's memory doesn't survive a shift change, a day off, or a handover to a colleague. Documentation isn't bureaucracy here — it's the mechanism by which a plan actually persists across the people who need to follow it.

The evidence: Individualised, documented care planning is consistently associated with improved continuity of care across shift changes in health services literature, distinct from assessment quality alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Care plans reflect genuinely individual assessment findings, not generic templates.	✗ Care plans for different patients with similar diagnoses read identically.
✓ Plans are visibly updated as patient condition changes, with a clear revision history.	✗ A plan remains unchanged despite documented deterioration or improvement.
✓ Staff taking over a shift find and understand the current plan quickly and confidently.	✗ Staff report difficulty locating or understanding the care plan at handover.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Care plans are individualised at creation but rarely revisited afterward.**
A good plan on day one that never gets updated becomes a stale plan by day five.

2 **Plans exist in a system that's hard to navigate quickly during a busy handover.**
Good content in an inaccessible format functions poorly under real time pressure.

3 **Revision happens for major changes but not smaller, cumulative ones.**
Gradual changes can accumulate into a significant gap between the plan and the patient's actual current state.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Compare a sample of care plans across similar diagnoses for genuine individualisation.

Week 2 Establish a clear expectation for when care plans must be revisited and updated.

Week 3 Test handover speed — can a staff member unfamiliar with a specific patient find and understand the plan quickly?

Ongoing Audit plan currency periodically against documented condition changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Compare plans side by side, not one at a time.
Templating is far more visible in direct comparison than in isolated review.

Time how long it takes staff to locate a plan during a simulated handover.
Speed and clarity under time pressure is the real test, not eventual retrievability.

E-LEARNING academy.gmj.ge/std4-9-care-plan — 30 min · complete before self-assessment

Standard 4.10 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Medication Prescribing Is Safe

ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR ADAPTED	SM FULL	ST FULL

4.10
NON-NEGOTIABLE
L1

THE STANDARD

Medication Prescribing Is Safe

Prescriptions are checked, legible, and follow a defined safety process — including a genuine second check for high-risk medications by a trained, designated person, whoever that is at this facility, not reliance on one clinician's judgement alone.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are prescriptions legible and complete, including dose, route, and frequency, without ambiguity?** *An illegible or incomplete prescription forces the dispensing or administering staff to guess or assume.* Doc: Prescription sample review	YES	PARTIAL	NO
2	**Is there a defined second-check process for high-risk medications specifically?** *General vigilance is not the same as a specific, mandatory second check for the medications most likely to cause serious harm.* Doc: Second-check protocol	YES	PARTIAL	NO
3	**Are prescribing errors, when caught, tracked and reviewed, not just quietly corrected?** *A caught error that's never reviewed teaches the system nothing about why it happened.* Doc: Error tracking log	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Prescription legibility and completeness check*	Reviews a sample of recent prescriptions for legibility, completeness, and absence of ambiguity.
DOCUMENT *Second-check protocol review*	Checks for a defined, followed second-check process specifically for high-risk medications.
ASK *Error-tracking interview*	Asks pharmacy or nursing staff how a caught prescribing error is documented and whether it leads to any review.

REFERENCES

WHO's Medication Without Harm Global Patient Safety Challenge (2017) identifies prescribing error as a leading, largely preventable contributor to medication-related harm worldwide, and does not specify which clinical role must perform the second check — only that one genuinely independent check occurs.

Standard 4.10 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Prescribing errors are among the most common preventable causes of patient harm precisely because they can happen silently — an illegible dose, a missed interaction, a decimal point error — with no obvious signal until the medication is already administered. This does not require a clinical pharmacist specifically. It requires a genuinely independent second person, trained for this function, whether that is a pharmacist, a second physician, or a senior nurse formally assigned the role.

The evidence: WHO's Medication Without Harm Global Patient Safety Challenge (2017) identifies prescribing error as a leading, largely preventable contributor to medication-related harm worldwide, and does not specify which clinical role must perform the second check — only that one genuinely independent check occurs.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Prescriptions are consistently legible, complete, and unambiguous.	✗ Prescriptions are frequently illegible or missing key information.
✓ A defined, genuinely followed second-check process exists for high-risk medications.	✗ No specific second-check process exists for high-risk medications beyond general care.
✓ Caught errors are tracked and reviewed, feeding back into practice.	✗ Caught errors are corrected silently with no tracking or review.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A second-check process exists on paper but is skipped under time pressure.**
A safety step that depends entirely on unhurried conditions will fail exactly when it's needed most — during a busy shift.

2 **Legibility is good for regular prescribers but poor for occasional or covering staff.**
Familiarity with local conventions and systems varies, and it shows in prescription quality.

3 **Errors are corrected but only the most serious ones get formally reviewed.**
Near-misses often contain the same lessons as serious errors, without the same scrutiny.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of recent prescriptions for legibility and completeness issues.

Week 2 Define or reinforce a specific second-check process for a named list of high-risk medications.

Week 3 Set up a simple error-tracking log, including near-misses, not only serious incidents.

Ongoing Review tracked errors periodically for patterns, feeding lessons back to prescribing staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the high-risk medication list specifically, not general policy.
A facility that can't name its own high-risk medications likely doesn't have a real second-check process for them.

Ask how a near-miss, not just a serious error, gets handled.
Near-miss handling reveals whether the system learns proactively or only reactively.

Ask who performs the second check, by name and role, not by job title assumption.
In a facility with no clinical pharmacist role, this function is often performed by a physician or senior nurse — confirm it is genuinely independent, not confirm it is a pharmacist specifically.

E-LEARNING academy.gmj.ge/std4-10-prescribing — 30 min · complete before self-assessment

	Standard 4.11 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **The Surgical Safety Checklist Is Actually Used**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.11
NON-NEGOTIABLE
L1

THE STANDARD

The Surgical Safety Checklist Is Actually Used

WHO's Surgical Safety Checklist is completed, out loud, as a genuine team pause for every procedure — not filed as paperwork after the fact.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the checklist completed out loud, as a team, before induction, before incision, and before the patient leaves theatre?** *All three checkpoints, spoken, not just the pre-induction one done and the rest skipped.* Doc: N/A — observed directly	YES	PARTIAL	NO
2	**Does every team member participate, not just the most senior person present?** *A checklist read by one person to a silent room misses its purpose — catching what any team member might notice.*	YES	PARTIAL	NO
3	**Is there evidence the checklist has actually changed a decision or caught an issue, not just been completed?** *A checklist that's never once caught anything real over time is worth questioning, not just checking for completion.* Doc: Any documented instance of checklist-caught issue	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Live checklist observation*	Directly observes checklist use during an actual procedure — or, where not possible, reviews the most recent documented instance in detail.
ASK *Team participation check*	Asks a non-senior team member — not the lead surgeon — to describe their role in the checklist process.
DOCUMENT *Checklist-catch history review*	Reviews records for any documented instance where the checklist process caught a genuine issue before it caused harm.

REFERENCES

[10] *Haynes AB, Weiser TG, Berry WR, et al. "A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population." N Engl J Med. 2009;360(5):491-499 — the original eight-country study found surgical complications fell from 11.0% to 7.0%, and in-hospital death from 1.5% to 0.8%, following genuine checklist implementation.*

Standard 4.11 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

The checklist's value comes entirely from being a real, spoken team moment, not a document. A checklist completed retrospectively, from memory, after the procedure, provides none of the safety benefit and all of the compliance appearance.

The evidence [10]: Haynes AB, Weiser TG, Berry WR, et al. "A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population." N Engl J Med. 2009;360(5):491-499 — the original eight-country study found surgical complications fell from 11.0% to 7.0%, and in-hospital death from 1.5% to 0.8%, following genuine checklist implementation.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The checklist is completed out loud, at all three checkpoints, with genuine team participation.	✗ The checklist is completed silently or retrospectively, as paperwork.
✓ Junior team members describe an active, expected role in the process, not passive presence.	✗ Only the most senior person present speaks during the checklist; others are passive.
✓ At least one documented instance exists of the checklist catching a real issue.	✗ Nobody can recall the checklist ever catching anything, across its entire use history.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **The pre-induction check happens reliably; the other two checkpoints are inconsistent.**
The first checkpoint often becomes routine while the later ones, under time pressure to finish, get compressed or skipped.

2 **The checklist is spoken but functions as a formality nobody expects to actually change anything.**
Ritual completion without genuine expectation of catching real issues loses most of the safety value.

3 **Junior staff are present during the checklist but not genuinely invited to speak up.**
Hierarchy can silence exactly the person most likely to notice something the senior team missed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Directly observe several procedures to assess genuine checklist practice versus formality.

Week 2 Brief the whole surgical team on the expectation that all three checkpoints happen, spoken, every time.

Week 3 Explicitly invite junior staff participation as part of the checklist process, not just presence.

Ongoing Track and share any instance where the checklist catches a genuine issue, reinforcing its real value to the team.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe live if at all possible, rather than relying on documentation alone.
Paperwork can show 100% completion while live practice tells a very different story.

Watch specifically for the second and third checkpoints, not just the first.
The pre-induction step is the most commonly performed genuinely; the later ones are where compliance most often erodes.

E-LEARNING academy.gmj.ge/std4-11-surgical-checklist — 30 min · complete before self-assessment

	Standard 4.12 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Anaesthesia Is Delivered Safely**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.12
NON-NEGOTIABLE
L1

THE STANDARD

Anaesthesia Is Delivered Safely

Anaesthesia follows defined safety protocols with continuous monitoring throughout the procedure, appropriate to the level of anaesthesia and the patient's specific risk profile.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is continuous monitoring maintained throughout the entire procedure, not just at induction and emergence?** *Gaps in monitoring during the middle of a long procedure are a real, documented risk pattern.* Doc: Monitoring record	YES	PARTIAL	NO
2	**Is the monitoring equipment appropriate to the level of anaesthesia and actually functioning, not just present?** *Equipment that's present but not properly calibrated or maintained provides false reassurance.* Doc: Equipment maintenance log	YES	PARTIAL	NO
3	**Is there a defined escalation protocol for anaesthesia-related complications?** *A protocol for the routine case is not the same as a protocol for when something goes wrong.* Doc: Escalation protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Monitoring continuity check*	Observes a procedure, or reviews detailed monitoring records, to check for continuous coverage throughout, not just at key transition points.
DOCUMENT *Equipment functionality check*	Checks maintenance and calibration records for anaesthesia monitoring equipment.
ASK *Escalation protocol interview*	Asks the anaesthesia team to describe the escalation protocol for a specific complication scenario.

REFERENCES

[30] *The WHO-WFSA International Standards for a Safe Practice of Anaesthesia establish continuous monitoring as a core, non-negotiable element of safe anaesthetic care across all resource settings.*

Standard 4.12 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Anaesthesia safety depends on continuous vigilance during a period when the patient cannot advocate for themselves at all. A protocol that exists but isn't followed under real conditions provides no more protection than no protocol.

The evidence [30]: The WHO-WFSA International Standards for a Safe Practice of Anaesthesia establish continuous monitoring as a core, non-negotiable element of safe anaesthetic care across all resource settings.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Monitoring is continuous throughout every procedure, with no gaps at any stage.	✗ Monitoring gaps exist during the middle portion of longer procedures.
✓ Equipment is regularly maintained and calibrated, with records to prove it.	✗ Equipment maintenance records are incomplete or absent.
✓ The anaesthesia team can describe a clear, specific escalation protocol confidently.	✗ The escalation protocol, if asked about, produces a vague or uncertain answer.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Monitoring is continuous for planned procedures but less consistent for emergency ones.**
Time pressure in emergency situations can compress steps that are reliably followed when there's more time.

2 **Equipment exists and is used but calibration records are inconsistent.**
Equipment that works today doesn't prove it was properly calibrated when it mattered most.

3 **An escalation protocol exists for common complications but not rarer, more serious ones.**
The rarest scenarios are also the ones staff have the least practised familiarity with.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent monitoring records for continuity gaps across a sample of procedures.

Week 2 Audit and update equipment calibration and maintenance records.

Week 3 Run a scenario-based briefing on escalation protocols, including less common complications.

Ongoing Periodically test staff recall of escalation protocols through scenario discussion, not just document review.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about a specific, less common complication, not the routine case.
General competence with common scenarios doesn't prove readiness for rarer, higher-stakes ones.

Check equipment records for gaps, not just presence of a maintenance schedule.
A schedule that exists on paper and one that's actually followed are different things.

E-LEARNING academy.gmj.ge/std4-12-anaesthesia — 30 min · complete before self-assessment

	Standard 4.13 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Surgical Site Infection Is Actively Prevented**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.13
NON-NEGOTIABLE
L1

THE STANDARD

Surgical Site Infection Is Actively Prevented

A defined surgical site infection prevention bundle is followed for every procedure — a specific, checkable set of practices, not general good intentions about cleanliness.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a specific, defined SSI prevention bundle followed for every procedure, not general practice?** *"We're careful about infection" is not the same as a specific, checkable bundle of practices.* Doc: SSI prevention bundle document	YES	PARTIAL	NO
2	**Is the facility's own SSI rate actually measured and tracked?** *Improvement isn't possible against a rate nobody is measuring.* Doc: SSI rate tracking data	YES	PARTIAL	NO
3	**Is bundle compliance checked per procedure, not assumed from general training?** *General training doesn't guarantee the bundle was actually followed on any specific occasion.* Doc: Per-procedure compliance record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Bundle definition and compliance review*	Reviews the specific defined SSI prevention bundle and checks per-procedure compliance records.
DOCUMENT *SSI rate tracking check*	Checks whether the facility measures and tracks its own SSI rate over time, and whether that data is used.
OBSERVE *Bundle practice observation*	Observes a procedure, or reviews detailed records, for evidence the specific bundle elements were followed, not just general precautions taken.

REFERENCES

[34] *WHO's Global Guidelines for the Prevention of Surgical Site Infection (2016) establish an evidence-based bundle of specific practices shown to reduce SSI rates across diverse healthcare settings.*

Standard 4.13 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Surgical site infections are among the most common healthcare-associated infections and among the most preventable, when a defined bundle of practices is genuinely and consistently followed rather than approximated.

The evidence [34]: WHO's Global Guidelines for the Prevention of Surgical Site Infection (2016) establish an evidence-based bundle of specific practices shown to reduce SSI rates across diverse healthcare settings.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, defined SSI prevention bundle is documented and consistently followed.	✗ No specific bundle exists beyond general infection control awareness.
✓ The facility's own SSI rate is actively measured, tracked, and used to guide improvement.	✗ SSI rate is not measured or tracked at all.
✓ Compliance with the bundle is checked per procedure, with clear records.	✗ Compliance is assumed from training history, with no per-procedure verification.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 A bundle exists and is generally known but compliance isn't checked per procedure.
Awareness of a bundle and verified compliance with it on a specific occasion are different levels of assurance.

2 SSI rate is tracked but the data isn't reviewed or acted on regularly.
Measurement without review provides no actual improvement pressure.

3 The bundle is followed well for high-risk procedures but less rigorously for routine ones.
Perceived risk level shouldn't determine bundle compliance, but often does in practice.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Document a specific SSI prevention bundle if one doesn't already exist in writing.

Week 2 Establish or verify SSI rate tracking, even in a simple form.

Week 3 Build per-procedure bundle compliance checking into the existing surgical checklist process.

Ongoing Review SSI rate data on a fixed schedule and feed findings back to the surgical team.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the SSI rate number directly.
A facility that can't produce its own rate isn't actually tracking it, whatever staff believe.

Check compliance for a routine procedure, not just a high-risk one.
Rigor often concentrates on perceived high-risk cases, leaving routine ones under-checked.

E-LEARNING academy.gmj.ge/std4-13-ssi-prevention — 30 min · complete before self-assessment

Standard 4.14 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

The Lab Has Quality Control

ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.14
NON-NEGOTIABLE
L1

THE STANDARD

The Lab Has Quality Control

Internal quality control runs before results are released, every batch — a genuine check against known standards, not results released on the assumption equipment is working correctly.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does internal quality control run before every batch of results is released, without exception?** *"Usually" or "when there's time" is not the same as a genuine non-negotiable step.* Doc: QC run records against release records	YES	PARTIAL	NO
2	**Is there a defined process for what happens when quality control fails?** *A QC failure needs a clear, followed response, not ad hoc decision-making in the moment.*	YES	PARTIAL	NO
3	**Are QC records retained and reviewable, not just checked and discarded?** *Retained records allow pattern detection over time that a single check can't reveal.* Doc: QC record retention log	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *QC-to-release timing check*	Compares quality control run timestamps against result release timestamps to verify QC genuinely precedes release, every time.
ASK *QC failure protocol interview*	Asks lab staff to describe exactly what happens when a quality control check fails.
DOCUMENT *Record retention check*	Checks whether QC records are retained over time and available for pattern review.

REFERENCES

Laboratory quality management frameworks, including CLSI and WHO laboratory quality standards, treat internal quality control as a non-negotiable precondition for result release, not an optional refinement.

Standard 4.14 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A lab result is only as trustworthy as the quality control behind it. Skipping quality control to save time trades a small, hidden risk against every single result released during the skipped period — a risk that's invisible until a clinical decision is made on a wrong number.

The evidence: Laboratory quality management frameworks, including CLSI and WHO laboratory quality standards, treat internal quality control as a non-negotiable precondition for result release, not an optional refinement.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Quality control precedes every batch release, verifiable through timestamped records.	✗ QC timing records show release happening before or without QC completion on some occasions.
✓ A clear, followed protocol exists for QC failures.	✗ Staff describe an uncertain or ad hoc response to QC failure.
✓ QC records are retained and available for trend review over time.	✗ QC records are checked once and not retained for later review.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 QC runs consistently for high-volume tests but is skipped under pressure for less common ones.
Perceived low stakes for infrequent tests can quietly erode the same rigor applied elsewhere.

2 A QC failure protocol exists but staff have never actually had to use it.
An untested protocol may look fine on paper and fail in practice under real pressure.

3 Records are retained but not actually reviewed for patterns over time.
Retention without review captures the data but misses the insight it could provide.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit a sample of recent result releases against QC timing records for any gaps.

Week 2 Document or reinforce a clear, specific protocol for QC failures.

Week 3 Establish a retention system for QC records if one doesn't already exist.

Ongoing Review retained QC data periodically for trends, not just individual pass/fail results.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Compare actual timestamps, don't accept a general assurance.
"We always do QC first" is a claim; timestamped records are evidence.

Ask about a specific, less common test, not the highest-volume one.
Rigor concentrated on high-volume tests can mask gaps elsewhere.

E-LEARNING academy.gmj.ge/std4-14-lab-qc — 30 min · complete before self-assessment

Standard 4.15 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Critical Lab Values Reach the Doctor Fast

ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.15
NON-NEGOTIABLE
L1

THE STANDARD

Critical Lab Values Reach the Doctor Fast

Critical results are reported through a faster, distinct pathway with confirmed receipt — not released into the same queue as routine results and left for someone to eventually notice.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a distinct, faster pathway for critical values, separate from routine result reporting?** *If critical values go into the same queue as everything else, speed depends on luck, not design.* Doc: Critical value pathway protocol	YES	PARTIAL	NO
2	**Is receipt of a critical value confirmed by the receiving clinician, not just assumed from transmission?** *A result sent is not the same as a result received and acknowledged by someone who can act on it.* Doc: Confirmed receipt log	YES	PARTIAL	NO
3	**Is there a defined escalation if the first attempt to reach a clinician fails?** *A single failed contact attempt shouldn't be where the process quietly stops.* Doc: Escalation protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Pathway distinction check*	Verifies a genuinely separate, faster pathway exists for critical values, distinct from routine reporting.
DOCUMENT *Confirmed receipt review*	Reviews records for evidence of confirmed receipt by a clinician, not just transmission.
ASK *Escalation protocol interview*	Asks lab staff what happens if the first attempt to reach a clinician about a critical value fails.

REFERENCES

Critical value reporting protocols with confirmed receipt are a widely adopted patient safety standard precisely because delayed recognition of urgent results is a well-documented, preventable harm pathway.

Standard 4.15 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A critical value sitting unread in a normal results queue provides zero clinical benefit despite technically having been "reported." The entire value of rapid critical-value reporting depends on a distinct pathway and confirmed receipt, not just faster generation of the result itself.

The evidence: Critical value reporting protocols with confirmed receipt are a widely adopted patient safety standard precisely because delayed recognition of urgent results is a well-documented, preventable harm pathway.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A distinct, faster pathway exists and is used consistently for critical values.	✗ Critical values are reported through the same queue as routine results.
✓ Receipt is confirmed by the receiving clinician every time, with records to prove it.	✗ No confirmation of receipt exists beyond the result having been sent.
✓ A clear escalation protocol exists and is known for failed first-contact attempts.	✗ Staff are uncertain what happens if the first contact attempt fails.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A distinct pathway exists during business hours but reverts to standard reporting overnight.**
Coverage gaps at specific times are a common, unstated exception to an otherwise good process.

2 **Receipt confirmation happens for phone calls but not for other communication channels used.**
Different channels don't have consistent confirmation the same way.

3 **An escalation protocol exists but the timeframe before escalating is vague.**
"Try again later" without a specific timeframe often means escalation happens inconsistently.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Map current critical value reporting against the actual, distinct pathway that should exist.

Week 2 Close any coverage gaps, particularly for out-of-hours periods.

Week 3 Define a specific timeframe and clear escalation trigger for failed first-contact attempts.

Ongoing Review confirmed-receipt records periodically for any pattern of delay.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask specifically about overnight and weekend coverage.
A pathway that works well during business hours may not extend to when it's tested least often but needed just as much.

Ask for a specific example, not a description of the policy.
A real recent example reveals whether the policy reflects practice.

E-LEARNING academy.gmj.ge/std4-15-critical-values — 30 min · complete before self-assessment

	Standard 4.16 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Specimens Are Correctly Identified**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.16
NON-NEGOTIABLE
L1

THE STANDARD

Specimens Are Correctly Identified

Specimen collection uses two identifiers, checked before collection and again before testing — a specific, doubled verification, not a single check assumed to be sufficient.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are two identifiers checked before specimen collection, not just one?** *A single identifier — a bed number, for instance — is not sufficient on its own.* Doc: Collection protocol	YES	PARTIAL	NO
2	**Is identity checked again before testing, independently of the collection-time check?** *A single check at collection doesn't catch an error introduced afterward, in transit or labelling.* Doc: Pre-testing verification record	YES	PARTIAL	NO
3	**Can staff describe what happens when identifiers don't match?** *A clear stop-and-resolve process, not proceeding anyway under time pressure, is essential.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Collection-point identifier check*	Observes specimen collection directly, or reviews protocol compliance records, for genuine two-identifier verification.
DOCUMENT *Pre-testing verification review*	Checks for a documented, independent identity verification step immediately before testing, separate from collection.
ASK *Mismatch response interview*	Asks staff to describe exactly what happens when identifiers don't match at either checkpoint.

REFERENCES

[13] *Two-identifier patient verification at specimen collection is a globally adopted patient safety standard specifically because single-identifier or single-check systems have repeatedly failed to catch misidentification in practice.*

Standard 4.16 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A misidentified specimen produces a confident, precise, completely wrong result — arguably more dangerous than an obviously failed test, because nothing about the output signals the error. Two-identifier checking at two separate points is specifically designed to catch the moment a single check would miss.

The evidence [13]: Two-identifier patient verification at specimen collection is a globally adopted patient safety standard specifically because single-identifier or single-check systems have repeatedly failed to catch misidentification in practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Two identifiers are consistently checked at both collection and pre-testing, independently.	✗ Only one identifier is checked, or checking happens at only one of the two required points.
✓ Staff describe a clear, confident stop-and-resolve process for any mismatch.	✗ Staff are uncertain what to do when identifiers don't match.
✓ Verification is genuine, not a formality performed without real attention.	✗ Verification appears to be a rushed formality rather than genuine attention.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Two-identifier checking happens reliably at collection but is skipped or assumed at pre-testing.**
The first check often becomes the well-established habit; the second, independent check is more easily eroded.

2 **The process is followed for inpatients but less consistently for outpatients or urgent cases.**
Time pressure and unfamiliarity both erode consistency, and urgent cases combine both.

3 **Staff know the process but occasionally skip it when "certain" they know the patient.**
Familiarity is precisely the condition under which shortcuts feel safe and occasionally aren't.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Directly observe specimen collection across a sample of cases to check genuine two-identifier practice.

Week 2 Reinforce or establish an independent pre-testing verification step.

Week 3 Brief all relevant staff on the mismatch response process, with a clear, simple stop-and-resolve rule.

Ongoing Spot-check practice periodically, particularly for urgent or outpatient specimens.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Watch for the second check specifically, not just the first.
The pre-testing verification is where compliance most commonly erodes first.

Ask what happens with a familiar, frequently-seen patient.
Familiarity-based shortcuts are the most common real-world failure mode for this exact requirement.

E-LEARNING academy.gmj.ge/std4-16-specimen-id — 30 min · complete before self-assessment

Standard 4.17 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Medication Storage Is Secure and Correct

ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.17
NON-NEGOTIABLE
L1

THE STANDARD

Medication Storage Is Secure and Correct

Medications are stored at the correct temperature and access is restricted to authorised staff — a specific, verifiable set of conditions, not general good housekeeping.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are temperature-sensitive medications stored within their required range, monitored and logged?** *A fridge that's "probably fine" is not the same as one with a monitored, logged temperature record.* Doc: Temperature monitoring log	YES	PARTIAL	NO
2	**Is access to medication storage restricted to authorised staff specifically, not generally available?** *General staff access, even with good intentions, undermines accountability and control.* Doc: Access control record	YES	PARTIAL	NO
3	**Are storage conditions checked routinely, not only when something seems wrong?** *Routine checking catches drift before it becomes a problem; reactive checking catches it after.*	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Temperature log review*	Reviews temperature monitoring logs for medication storage for consistency and any unaddressed excursions.
OBSERVE *Access control check*	Checks whether medication storage access is genuinely restricted, not left open or accessible to unauthorised staff.
DOCUMENT *Routine check schedule review*	Verifies storage conditions are checked on a routine schedule, not only reactively.

REFERENCES

[36] *WHO's Medication Without Harm initiative identifies storage-related medication errors as a distinct, trackable category within the broader medication safety challenge, separate from prescribing and administration errors.*

Standard 4.17 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Medication effectiveness and safety both depend on storage conditions that are invisible in the final product — a medication stored incorrectly looks identical to one stored correctly, right up until it's administered and doesn't work as expected, or worse.

The evidence [36]: WHO's Medication Without Harm initiative identifies storage-related medication errors as a distinct, trackable category within the broader medication safety challenge, separate from prescribing and administration errors.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Temperature-sensitive storage is consistently monitored, logged, and within range.	✗ Temperature logs show gaps or unaddressed excursions outside the safe range.
✓ Access is genuinely restricted to authorised staff, verifiable in practice.	✗ Storage access is effectively open to any staff member, regardless of authorisation.
✓ Routine checks happen on a defined schedule, catching drift early.	✗ Checks happen only reactively, after a problem is suspected.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Temperature is monitored but excursions aren't consistently followed up.**
Detection without response provides only partial protection.

2 **Access restriction exists on paper but the physical lock or control isn't consistently enforced.**
A policy requiring restricted access means little if the door is routinely left open.

3 **Routine checks happen for high-value medications but not consistently across all storage areas.**
Perceived risk level again shapes where rigor concentrates, sometimes unevenly.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent temperature logs for gaps or unaddressed excursions.

Week 2 Verify and reinforce physical access control to medication storage areas.

Week 3 Establish a routine check schedule covering all storage areas, not only high-value ones.

Ongoing Review temperature and access logs periodically for any drift or lapse.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check the log for gaps, not just current readings.
A current reading within range says nothing about what happened overnight or over a weekend.

Try accessing storage yourself, if appropriate, to test real restriction.
A stated policy and an actually enforced physical control aren't always the same thing.

E-LEARNING academy.gmj.ge/std4-17-medication-storage — 30 min · complete before self-assessment

	Standard 4.18 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **High-Alert Medications Get Extra Safeguards**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.18
NON-NEGOTIABLE
L1

THE STANDARD

High-Alert Medications Get Extra Safeguards

Insulin, anticoagulants, and concentrated electrolytes have an independent double-check before administration — a specific, mandatory second person, not the same clinician checking their own work twice.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a defined, named list of high-alert medications requiring an independent double-check?** *A vague sense of "being extra careful" with certain medications is not the same as a specific, named list.* Doc: High-alert medication list	YES	PARTIAL	NO
2	**Is the double-check performed by a genuinely independent second person, not the same clinician?** *Self-verification doesn't provide the independent perspective the safeguard is designed to add.* Doc: Double-check protocol and records	YES	PARTIAL	NO
3	**Is the double-check documented, not just assumed to have happened?** *An undocumented check leaves no way to verify it actually occurred as intended.* Doc: Documented double-check record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *High-alert list verification*	Checks for a specific, named list of high-alert medications and whether it matches recognised categories.
OBSERVE *Independent double-check observation*	Observes or reviews records of the double-check process, checking specifically for genuine independence between the two checkers.
DOCUMENT *Documentation completeness check*	Reviews administration records for high-alert medications to confirm the double-check is documented, not just assumed.

REFERENCES

[36] *WHO's Medication Without Harm initiative specifically names high-alert medications — including insulin, anticoagulants, and concentrated electrolytes — as requiring targeted, additional safeguards beyond standard medication safety practice.*

Standard 4.18 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

High-alert medications carry disproportionate harm potential from even small errors, which is precisely why they warrant a safeguard beyond what's applied to medications generally. A single clinician checking their own work twice doesn't provide genuine independent verification — the same blind spot that caused an error the first time is likely to persist on a self-check.

The evidence [36]: WHO's Medication Without Harm initiative specifically names high-alert medications — including insulin, anticoagulants, and concentrated electrolytes — as requiring targeted, additional safeguards beyond standard medication safety practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, named high-alert medication list exists and matches recognised categories. ✓ Double-checks are performed by a genuinely independent second person, every time. ✓ Every double-check is documented, with clear records available for review.	✗ No specific high-alert list exists beyond general caution. ✗ Double-checks are performed by the same person who prepared the medication. ✗ Double-checks are described as routine but no documentation exists to confirm they happened.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A high-alert list exists but is incomplete relative to recognised categories.**
An outdated or partial list leaves some genuinely high-risk medications without the extra safeguard.

2 **Independent double-checking happens during busy hours less reliably than quiet ones.**
The safeguard is most likely to be skipped exactly when time pressure is highest — often also when error risk is highest.

3 **Double-checks happen but documentation is inconsistent.**
A verbal culture of checking without documentation makes the practice unverifiable after the fact.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Compare the current high-alert medication list against recognised categories and close any gaps.

Week 2 Reinforce the requirement for genuine independence in double-checking, not self-verification.

Week 3 Build documentation of the double-check directly into the administration record process.

Ongoing Audit double-check documentation periodically, particularly during historically busier shifts.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask who performed the double-check on a specific recent administration.
A specific name check reveals whether independence is genuine or assumed.

Check documentation completeness during a busy period specifically.
Gaps concentrate under pressure — checking a calm period alone can miss this.

E-LEARNING academy.gmj.ge/std4-18-high-alert-meds — 30 min · complete before self-assessment

	Standard 4.19 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **Medication Reconciliation Actually Happens**	ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR ADAPTED	SM FULL	ST FULL

4.19
NON-NEGOTIABLE
L1

THE STANDARD

Medication Reconciliation Actually Happens

Admission and discharge medication lists are compared and discrepancies resolved by a trained, designated person — a genuine, documented reconciliation process, not an assumption that the lists already match, and not dependent on a clinical pharmacist role this facility may not have.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a formal reconciliation process completed at both admission and discharge, comparing medication lists directly?** *Reconciliation only at one transition point, not both, leaves a real gap.* Doc: Reconciliation record, admission and discharge	YES	PARTIAL	NO
2	**Are discrepancies found during reconciliation actually resolved and documented, not just noted?** *Identifying a discrepancy without resolving it provides no real safety benefit.* Doc: Discrepancy resolution record	YES	PARTIAL	NO
3	**Does the process include the patient's own account of what they actually take, not only prior records?** *Prior records can be outdated or incomplete — the patient's own current account is a necessary cross-check.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Reconciliation completeness check*	Reviews records to confirm reconciliation happens at both admission and discharge, not only one transition point.
DOCUMENT *Discrepancy resolution review*	Checks whether discrepancies identified during reconciliation are actually resolved and documented, not just noted.
ASK *Patient-account inclusion check*	Asks staff whether and how the patient's own account of their current medications is incorporated into reconciliation.

REFERENCES

WHO's Medication Without Harm initiative identifies transitions of care as a high-risk point specifically requiring structured reconciliation, distinct from routine prescribing safety measures — the requirement is the structured process, not a specific staffing model.

Standard 4.19 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Medication discrepancies at transitions of care — admission, transfer, discharge — are one of the most common and most preventable sources of medication-related harm, precisely because they occur at moments when responsibility for the patient's medication list changes hands. Reconciliation is a function, not a job title — it can be performed by a trained nurse or physician exactly as reliably as a pharmacist, provided the person doing it is specifically trained for it and it is not left to whoever happens to be available.

The evidence: WHO's Medication Without Harm initiative identifies transitions of care as a high-risk point specifically requiring structured reconciliation, distinct from routine prescribing safety measures — the requirement is the structured process, not a specific staffing model.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Reconciliation happens consistently at both admission and discharge, with clear records.	✗ Reconciliation happens at only one transition point, or inconsistently at either.
✓ Discrepancies are resolved and documented, not left open.	✗ Discrepancies are noted but left unresolved in the record.
✓ The patient's own account is actively sought and incorporated, not just prior records relied on.	✗ The process relies solely on prior records without checking the patient's own current account.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Reconciliation happens reliably at admission but is rushed or skipped at discharge.**
Discharge is often a busier, more time-pressured moment, and the safeguard erodes accordingly.

2 **Discrepancies are documented as found but follow-up resolution isn't consistently tracked.**
Identification without a closed loop leaves the actual risk unaddressed.

3 **Patient input is sought for coherent patients but skipped for those who are confused or unable to communicate clearly.**
The patients least able to advocate for accuracy in their own medication list are often the ones for whom the cross-check matters most.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of recent admissions and discharges for reconciliation completeness.

Week 2 Reinforce discharge reconciliation specifically, given it's the more commonly rushed transition.

Week 3 Build a simple discrepancy resolution tracker so identified issues don't go unresolved.

Ongoing Audit reconciliation completeness periodically, particularly at discharge and for patients with communication barriers.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check discharge reconciliation specifically, not just admission.
Admission reconciliation is more reliably performed; discharge is where gaps concentrate.

Ask how reconciliation works for a patient who can't easily communicate.
This reveals whether the process has a real answer for its hardest, highest-risk case.

If no clinical pharmacist role exists at this facility, ask specifically who is trained to perform reconciliation and how they were trained.
A facility without a pharmacy department can still meet this fully — the question is whether reconciliation is a real, owned function for someone, not whether that someone has a specific job title.

E-LEARNING academy.gmj.ge/std4-19-medication-reconciliation — 30 min · complete before self-assessment

	Standard 4.20 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Patient Identified Correctly at Every Point of Contact**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.20
NON-NEGOTIABLE
L1

THE STANDARD

Patient Identified Correctly at Every Point of Contact

Every patient is verified using at least two identifiers before any medication, procedure, blood product, or specimen collection — not only for laboratory work, but at every point contact could go wrong.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are two identifiers checked before every medication administration, not only during specimen collection?** *The same two-identifier discipline applied to lab work needs to extend to medication rounds.* Doc: Medication administration protocol	YES	PARTIAL	NO
2	**Is a room or bed number ever used as a patient identifier?** *Room and bed numbers change and are never acceptable as an identifier on their own.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is patient identification checked before blood products and before procedures, independently each time?** *Each new point of contact needs its own check, not reliance on identification done earlier in the encounter.* Doc: Procedure and transfusion identification record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Medication round observation*	Observes a medication round directly, checking whether two identifiers are verified before each administration.
ASK *Staff practice interview*	Asks staff what counts as an acceptable identifier, checking specifically that room or bed number is never used alone.
DOCUMENT *Cross-point consistency review*	Reviews identification practice across medication, blood product, and procedural records for consistency, not just lab specimens.

REFERENCES

[13] *Correct patient identification is the first of JCI's six International Patient Safety Goals, applied universally across medication administration, blood products, and procedures — not treated as a department-specific requirement.*

Standard 4.20 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A misidentified patient at any point of contact — not just specimen collection — can result in the wrong medication, the wrong procedure, or the wrong blood product being given to the wrong person. This has to be a universal habit applied everywhere care happens, not a rule that lives only inside one department's protocol.

The evidence [13]: Correct patient identification is the first of JCI's six International Patient Safety Goals, applied universally across medication administration, blood products, and procedures — not treated as a department-specific requirement.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Two identifiers are checked before every medication, procedure, and blood product administration.	✗ Two-identifier checking happens for lab specimens but not consistently for medication rounds.
✓ Staff can clearly state that room or bed number is never an acceptable identifier alone.	✗ Room or bed number is used as a de facto identifier by some staff.
✓ Identification practice is consistent across every point of contact, not concentrated only in the lab.	✗ Identification is treated as a one-time check at admission rather than repeated at each point of contact.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **The practice is strong in the lab, where it was first introduced, but hasn't spread to other departments.**
A safety practice introduced for one purpose sometimes doesn't generalise without deliberate effort.

2 **Staff verify identity but use a mix of acceptable and unacceptable identifiers inconsistently.**
Partial adherence to the rule can be harder to catch than its complete absence.

3 **Verification happens once at admission and is assumed to carry forward for the rest of the stay.**
A single admission check doesn't protect against the specific risk of a mix-up during a later intervention.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit medication rounds, procedures, and blood product administration for consistent two-identifier practice.

Week 2 Brief all clinical staff explicitly that room or bed number is never acceptable alone.

Week 3 Extend the lab's existing two-identifier discipline formally to medication and procedural contexts.

Ongoing Spot-check identification practice across different departments, not only the lab.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe a medication round directly, not just review policy.
This is where the practice most commonly fails to generalise from where it started.

Ask specifically whether room or bed number is ever used.
A direct, specific question often reveals what a general policy question won't.

E-LEARNING academy.gmj.ge/std4-20-patient-identification — 30 min · complete before self-assessment

	Standard 4.21 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Falls Risk Assessed and Actively Prevented**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.21
NON-NEGOTIABLE
L1

THE STANDARD

Falls Risk Assessed and Actively Prevented

Every patient is assessed for fall risk on admission using a structured tool, with prevention measures implemented for anyone identified at risk, and every fall tracked as a safety indicator.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every patient assessed for fall risk on admission using a structured, validated tool?** *Not clinical impression alone — a defined scoring tool such as the Morse Fall Scale or an equivalent.* Doc: Fall risk assessment tool and completed sample	YES	PARTIAL	NO
2	**Are specific prevention measures implemented for patients identified as high risk?** *A completed assessment that doesn't change anything about care provides no real protection.* Doc: Prevention measures record for high-risk patients	YES	PARTIAL	NO
3	**Are falls tracked as a safety indicator, with each fall reviewed?** *Tracking without review misses the chance to learn from each incident.* Doc: Fall incident log and review record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Assessment tool and completion review*	Reviews the fall risk assessment tool used and checks completion consistency across a sample of admissions.
OBSERVE *Prevention measures check*	Checks whether patients currently identified as high risk have visible, specific prevention measures in place.
DOCUMENT *Incident tracking review*	Reviews the fall incident log for tracking consistency and evidence of review following each fall.

REFERENCES

[8] *Dykes PC, Carroll DL, Hurley A, et al. Fall prevention in acute care hospitals: a randomized trial. JAMA. 2010;304(17):1912-1918 — a structured, tailored fall prevention intervention significantly reduced patient falls in a randomized acute care trial.*

Standard 4.21 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Falls are consistently one of the most common preventable causes of patient harm in hospital care, and unlike many other risks, a structured assessment tool can identify who is actually at risk with real accuracy — which only matters if the facility acts on what the assessment finds.

The evidence [8]: Dykes PC, Carroll DL, Hurley A, et al. Fall prevention in acute care hospitals: a randomized trial. JAMA. 2010;304(17):1912-1918 — a structured, tailored fall prevention intervention significantly reduced patient falls in a randomized acute care trial.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured, validated fall risk tool is used consistently on admission.	✗ Fall risk assessment relies on informal clinical impression rather than a structured tool.
✓ High-risk patients have specific, visible prevention measures in place.	✗ High-risk patients are identified but no specific prevention measures follow.
✓ Every fall is logged and reviewed, with lessons feeding back into practice.	✗ Falls are not consistently logged, or logged without any review.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Assessment happens on admission but isn't repeated as a patient's condition or medication changes.**
Fall risk can change significantly during a stay, and a single admission-day assessment can miss that shift.

2 **Prevention measures exist but are generic rather than tailored to the specific risk factors identified.**
A standard set of precautions applied uniformly captures less benefit than measures matched to why a specific patient is at risk.

3 **Falls are logged but review focuses only on the most serious injuries.**
Falls without serious injury still carry the same lessons about what nearly went wrong.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Adopt or confirm use of a structured, validated fall risk assessment tool.

Week 2 Ensure specific, tailored prevention measures follow every high-risk identification.

Week 3 Establish a fall incident log with a defined review process for every fall, not only serious ones.

Ongoing Reassess fall risk at meaningful points during a stay, not only at admission.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check whether reassessment happens beyond admission.
A single-point assessment is a common, specific gap worth checking directly.

Ask to see prevention measures for a specific current high-risk patient.
A real, current example reveals whether assessment actually translates into action.

E-LEARNING academy.gmj.ge/std4-21-falls-prevention — 30 min · complete before self-assessment

Standard 4.22 **CORE** · *Standard 4: Care & Treatment*

Look-Alike, Sound-Alike Medications Are Specifically Managed

ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.22
CORE
L1

THE STANDARD

Look-Alike, Sound-Alike Medications Are Specifically Managed

Medications with names or packaging that could be confused with another are identified on a specific list and managed with distinct safeguards — separated storage, distinct labelling, or an independent check — not treated the same as any other medication.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does a specific, named list of look-alike, sound-alike medications exist for this facility's own formulary?** *Generic awareness of the concept is not the same as a specific list for what this facility actually stocks.* Doc: LASA medication list	YES	PARTIAL	NO
2	**Are LASA medications stored separately or distinctly labelled to prevent mix-up?** *Physical or visual separation, not reliance on staff memory alone.* Doc: Storage or labelling arrangement	YES	PARTIAL	NO
3	**Is there a specific check step for LASA medications distinct from general dispensing practice?** *An additional safeguard specific to this risk, not just standard dispensing care.* Doc: LASA-specific check protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *LASA list review*	Reviews the facility's specific LASA medication list against its actual formulary for completeness.
OBSERVE *Storage separation check*	Checks physical storage or labelling arrangements for identified LASA medications.
ASK *Dispensing staff interview*	Asks pharmacy or dispensing staff to describe the specific check applied to LASA medications.

REFERENCES

Look-alike, sound-alike medication confusion is a recognised, distinct medication safety category in WHO and international patient safety literature, requiring targeted controls separate from general prescribing safety measures.

Standard 4.22 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A mix-up between two medications with similar names or similar packaging is a distinctly different error mechanism from a general prescribing mistake, and it defeats safeguards designed for other kinds of errors. It needs its own, specific defence.

The evidence: Look-alike, sound-alike medication confusion is a recognised, distinct medication safety category in WHO and international patient safety literature, requiring targeted controls separate from general prescribing safety measures.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, facility-relevant LASA list exists and is kept current.	✗ No specific LASA list exists beyond general staff awareness of the concept.
✓ LASA medications are physically separated or distinctly labelled.	✗ LASA medications are stored identically to any other medication, with no distinguishing measure.
✓ A specific additional check step applies to LASA dispensing, beyond general practice.	✗ No additional check exists specific to this risk category.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A LASA list exists but wasn't built from this facility's own formulary, so it misses relevant local risks.**
A generic list doesn't substitute for one reviewed against what's actually stocked here.

2 **Separation exists for high-profile LASA pairs but not comprehensively.**
Awareness often concentrates on well-known examples while missing less famous but equally risky pairs.

3 **A distinguishing measure exists but staff don't consistently use it under time pressure.**
A safeguard that depends entirely on unhurried conditions can fail exactly when needed most.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Build a specific LASA list reviewed against this facility's actual formulary.

Week 2 Implement physical separation or distinct labelling for identified pairs.

Week 3 Define and brief staff on a specific additional check for LASA dispensing.

Ongoing Review the LASA list whenever the formulary changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the list itself, not a general description of awareness.
A specific, named list is the only real evidence this has been deliberately addressed.

Check storage for a specific LASA pair directly.
Physical verification reveals more than a policy description.

E-LEARNING academy.gmj.ge/std4-22-lasa-medications — 30 min · complete before self-assessment

	Standard 4.23 **CORE** · *Standard 4: Care & Treatment* **Restraint and Seclusion Use Is Governed and Minimised**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

4.23
CORE
L1

THE STANDARD

Restraint and Seclusion Use Is Governed and Minimised

Physical or chemical restraint and seclusion are used only under a defined protocol, as a last resort, time-limited, monitored, and documented — never as a routine or convenience practice.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a written protocol governing when restraint or seclusion may be used, as a last resort only?** *A specific, documented threshold, not a general judgement call left to individual staff.* Doc: Restraint and seclusion protocol	YES	PARTIAL	NO
2	**Is every use time-limited, monitored, and documented, with a defined review point?** *Open-ended or unmonitored use is not acceptable under any protocol.* Doc: Restraint/seclusion use log	YES	PARTIAL	NO
3	**Is restraint or seclusion use reviewed to check it isn't becoming routine for particular patients or situations?** *Pattern review catches drift from last-resort toward habitual use.* Doc: Usage pattern review record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Protocol review*	Reviews the written restraint and seclusion protocol for a clear last-resort threshold and defined limits.
DOCUMENT *Use log review*	Reviews the use log for time limits, monitoring records, and documented rationale for each instance.
ASK *Staff threshold interview*	Asks clinical staff to describe the specific threshold for using restraint or seclusion, testing genuine understanding versus a vague sense of the policy.

REFERENCES

Restraint and seclusion governance is an established patient rights and safety standard in international accreditation frameworks, reflecting recognised risk of physical and psychological harm from unmonitored or prolonged use.

Standard 4.23 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Restraint and seclusion carry real physical and psychological risk to patients and represent a significant ethical boundary in care. Without a specific, enforced protocol, use can drift from genuine last-resort safety measure toward convenience, which is precisely the pattern this standard exists to prevent.

The evidence: Restraint and seclusion governance is an established patient rights and safety standard in international accreditation frameworks, reflecting recognised risk of physical and psychological harm from unmonitored or prolonged use.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, written protocol defines restraint and seclusion as genuine last resort, with clear limits.	✗ No specific protocol exists beyond general clinical judgement.
✓ Every use is time-limited, monitored, and documented with a clear rationale.	✗ Use log entries show open-ended duration or missing monitoring records.
✓ Usage patterns are reviewed to catch any drift toward routine or convenience use.	✗ No review exists to check whether use is becoming routine for specific situations.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A protocol exists but staff apply it inconsistently depending on individual judgement.**
A written threshold doesn't guarantee consistent application without active reinforcement.

2 **Documentation happens but review of usage patterns over time doesn't occur.**
Individual instances can each look justified while a pattern reveals a genuine drift.

3 **Time limits exist on paper but aren't consistently enforced in practice.**
A stated limit that's routinely extended without documented justification functions as no limit at all.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review the current restraint and seclusion protocol for specificity and last-resort framing.

Week 2 Audit recent use log entries for time limits, monitoring, and documented rationale.

Week 3 Brief clinical staff specifically on the threshold and reinforce consistent application.

Ongoing Review usage patterns periodically for any drift toward routine use.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to describe the threshold in their own words, not recite the policy.
Genuine understanding versus rote familiarity shows in how the answer is framed.

Check for pattern review, not just individual case documentation.
Drift toward routine use is only visible across multiple instances, not any single one.

E-LEARNING academy.gmj.ge/std4-23-restraint-seclusion — 30 min · complete before self-assessment

Standard 4.24 **CORE** · *Standard 4: Care & Treatment*

Nutrition and Therapeutic Diet Needs Are Actively Managed

ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.24
CORE
L1

THE STANDARD

Nutrition and Therapeutic Diet Needs Are Actively Managed

Patients are screened for nutritional risk, therapeutic diets are correctly identified and delivered, and food handling meets basic safety standards — nutrition treated as part of clinical care, not a hospitality afterthought.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every patient screened for nutritional risk on admission?** *A specific screening step, not an assumption that nutrition will be addressed informally if it becomes relevant.* Doc: Nutritional screening tool and record	YES	PARTIAL	NO
2	**Are therapeutic diets correctly identified, prescribed, and verified as delivered to the right patient?** *A diet order that doesn't reliably reach the correct patient provides no real benefit.* Doc: Therapeutic diet order and delivery verification	YES	PARTIAL	NO
3	**Does food handling meet basic safety standards, verified directly, not assumed?** *Kitchen and food service hygiene checked directly, the same discipline applied to clinical infection control.* Doc: Food safety inspection record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Nutritional screening review*	Reviews the nutritional screening tool and checks completion consistency across a sample of admissions.
OBSERVE *Diet delivery verification*	Checks whether therapeutic diet orders are correctly matched to the right patient at the point of delivery.
OBSERVE *Food safety check*	Directly inspects food handling and storage practices against basic safety standards.

REFERENCES

Nutritional screening and therapeutic diet management are recognised elements of clinical quality frameworks, reflecting evidence that nutritional status materially affects recovery, complication rates, and length of stay.

Standard 4.24 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Malnutrition on admission, or nutritional decline during a stay, measurably affects recovery and complication rates, yet nutrition is often managed as a hospitality function rather than a clinical one. A patient on the wrong diet, or an unscreened nutritional risk, is a preventable gap in care.

The evidence: Nutritional screening and therapeutic diet management are recognised elements of clinical quality frameworks, reflecting evidence that nutritional status materially affects recovery, complication rates, and length of stay.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Nutritional risk screening happens consistently on admission.	✗ No structured nutritional screening exists; nutrition is addressed only if a problem becomes obvious.
✓ Therapeutic diets are correctly identified, ordered, and verified at delivery.	✗ Therapeutic diet errors occur without a verification step to catch them.
✓ Food handling and storage meet basic, verifiable safety standards.	✗ Food safety practices show gaps when directly inspected.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Screening happens for complex or clearly frail patients but not systematically for everyone.**
Nutritional risk isn't always visually obvious, and selective screening misses less apparent cases.

2 **Diet orders are correct but delivery verification relies on informal tray-matching.**
An informal process is more prone to error than a defined verification step.

3 **Food safety practices are generally sound but specific storage temperature logging is inconsistent.**
Overall good practice can still have a specific, checkable documentation gap.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current nutritional screening practice for consistency across all admissions.

Week 2 Establish or reinforce a specific verification step matching therapeutic diet orders to delivery.

Week 3 Conduct a direct food safety inspection and address any gaps found.

Ongoing Audit nutritional screening and diet delivery accuracy periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the screening tool and a completed sample, not a description of general awareness.
A specific, used tool is the real evidence, not stated good intentions.

Inspect food handling directly rather than relying on a self-report.
Direct observation catches gaps a description of policy wouldn't reveal.

E-LEARNING academy.gmj.ge/std4-24-nutrition — 30 min · complete before self-assessment

	Standard 4.25 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **Deteriorating Patients Are Caught Before the Crisis, Not After**	ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.25
NON-NEGOTIABLE
L1

THE STANDARD

Deteriorating Patients Are Caught Before the Crisis, Not After

A structured early warning score is calculated from routine vital signs, tracked over time, and triggers a defined escalation response when it crosses a threshold — not left to individual clinical impression alone to notice a patient is declining.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is a structured early warning score calculated from routine vital signs, not just individual readings checked in isolation?** *A composite score tracking trend, not six separate numbers each compared to a normal range independently.* Doc: Early warning score tool and completed sample	YES	PARTIAL	NO
2	**Is there a defined escalation response triggered when the score crosses a specific threshold?** *A specific, named response — not "someone will probably notice and do something."* Doc: Escalation protocol document	YES	PARTIAL	NO
3	**Is the score recalculated on a defined schedule, not only when a nurse happens to have time?** *A schedule that holds even during busy shifts is what actually catches deterioration in time.* Doc: Scoring frequency schedule	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Scoring consistency review*	Reviews a sample of patient records for consistent early warning score calculation against the defined schedule.
OBSERVE *Escalation response check*	Checks whether a recent above-threshold score actually triggered the defined escalation response, not just documentation of the score itself.
ASK *Staff threshold interview*	Asks nursing staff to state the escalation threshold and describe exactly what they do when a patient crosses it.

REFERENCES

[20] *The National Early Warning Score (NEWS2) composite scoring approach, originally developed in the United Kingdom, has become an internationally adopted hospital assessment standard, shown to predict unplanned ICU transfers and clinical deterioration with strong accuracy.*

Standard 4.25 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A patient's vital signs typically shift measurably before a visible crisis — a cardiac arrest, an unplanned ICU transfer — but only if someone is systematically tracking the trend, not just checking each reading against normal ranges in isolation. A structured score turns scattered observations into an early signal, and a defined escalation response turns that signal into action before the crisis, not after.

The evidence [20]: The National Early Warning Score (NEWS2) composite scoring approach, originally developed in the United Kingdom, has become an internationally adopted hospital assessment standard, shown to predict unplanned ICU transfers and clinical deterioration with strong accuracy.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured early warning score is calculated consistently on a defined schedule.	✗ Vital signs are recorded but never combined into a structured trending score.
✓ A specific, named escalation response is triggered and followed when the threshold is crossed.	✗ No defined escalation response exists beyond general clinical judgement.
✓ Staff can state the threshold and describe the escalation process confidently and specifically.	✗ Staff are uncertain what score should trigger escalation, or what happens next.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Scoring happens reliably on day shifts but drops off overnight when staffing is thinner.**
The exact conditions that make deterioration harder to catch informally are also when the structured backup is most likely to lapse.

2 **The score is calculated but the escalation threshold is vague or inconsistently applied.**
A score without a clear, consistently enforced action threshold provides information without protection.

3 **Escalation happens for the most severe scores but not consistently for moderate, early-warning-range scores.**
The entire value of an early warning system is catching deterioration before it becomes severe.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current vital sign recording practice and whether it's ever combined into a structured score.

Week 2 Adopt a structured early warning tool and define a specific escalation threshold and response.

Week 3 Brief all clinical staff, with particular attention to overnight and weekend coverage.

Ongoing Audit scoring consistency and escalation follow-through periodically, especially outside daytime hours.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check overnight and weekend records specifically, not just daytime samples.
Coverage gaps concentrate exactly where staffing thins.

Ask for a real example of an above-threshold score and trace what actually happened next.
A real example reveals whether escalation is genuine, not just documented as a policy.

E-LEARNING academy.gmj.ge/std4-25-deteriorating-patient — 30 min · complete before self-assessment

	Standard 4.26 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Sepsis Is Recognised and Treated Within the Hour**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.26
NON-NEGOTIABLE
L1

THE STANDARD

Sepsis Is Recognised and Treated Within the Hour

Staff are trained to recognise sepsis using a standardised screening approach, and a defined care bundle — including prompt antibiotics and fluid resuscitation — is initiated without delay once sepsis is suspected, not after a diagnosis is fully confirmed.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a standardised screening approach staff use to identify possible sepsis, not informal clinical suspicion alone?** *A specific, structured screening tool, not left to individual recognition varying by experience.* Doc: Sepsis screening tool	YES	PARTIAL	NO
2	**Does a defined care bundle begin immediately on suspicion, not after full diagnostic confirmation?** *Suspicion triggers action; waiting for certainty costs the time that matters most.* Doc: Sepsis bundle protocol and timing record	YES	PARTIAL	NO
3	**Is time from suspicion to first antibiotic dose tracked as a specific, monitored metric?** *An untracked interval cannot be improved, and clinicians won't know if delays are happening.* Doc: Time-to-antibiotic tracking record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Screening tool and bundle review*	Reviews the sepsis screening tool and defined care bundle for specificity and adherence in a sample of recent cases.
DOCUMENT *Time-to-treatment tracking check*	Reviews whether time from suspicion to first antibiotic dose is tracked and monitored as a specific metric.
ASK *Staff recognition interview*	Asks front-line clinical staff to describe how they recognise possible sepsis and what happens in the first hour after suspicion.

REFERENCES

[9] *Evans L, Rhodes A, Alhazzani W, et al. Surviving Sepsis Campaign: international guidelines for management of sepsis and septic shock 2021. Crit Care Med. 2021;49(11):e1063-e1143 — establishes time-sensitive bundled care, including prompt antibiotics and fluid resuscitation, as the international standard of care once sepsis is suspected.*

Standard 4.26 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Sepsis kills through delay as much as through the underlying infection itself — every hour without appropriate treatment measurably increases mortality. Waiting for full diagnostic certainty before acting, rather than initiating treatment on reasonable suspicion, is one of the most consistently documented preventable failures in sepsis care worldwide.

The evidence [9]: Evans L, Rhodes A, Alhazzani W, et al. Surviving Sepsis Campaign: international guidelines for management of sepsis and septic shock 2021. Crit Care Med. 2021;49(11):e1063-e1143 — establishes time-sensitive bundled care, including prompt antibiotics and fluid resuscitation, as the international standard of care once sepsis is suspected.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A standardised screening tool is used consistently to identify possible sepsis.	✗ Sepsis recognition relies entirely on informal clinical impression, varying significantly by individual staff experience.
✓ The care bundle begins on suspicion, not after full diagnostic confirmation.	✗ Treatment waits for full diagnostic confirmation before beginning.
✓ Time-to-antibiotic is tracked and reviewed as a specific quality metric.	✗ No tracking exists of the time between suspicion and first treatment.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Screening is strong in the emergency department but less consistent for patients who deteriorate on general wards.**
Sepsis awareness and protocol familiarity is often concentrated where it was first introduced.

2 **The bundle exists and is used, but tracking of the time interval itself was never implemented.**
Good practice that isn't measured cannot demonstrate its own consistency or improve further.

3 **Recognition and initial treatment are strong for classic presentations but less reliable for atypical ones.**
Sepsis can present subtly, particularly in elderly or immunocompromised patients, and screening tools calibrated for classic presentations can miss these.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent cases for screening consistency and time from suspicion to first antibiotic dose.

Week 2 Adopt or reinforce a standardised sepsis screening tool across all clinical areas, not just the emergency department.

Week 3 Establish time-to-antibiotic tracking as a routine, reviewed quality metric.

Ongoing Review tracked cases periodically, with particular attention to atypical presentations and non-emergency-department settings.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about ward-based recognition specifically, not just emergency department practice.
Sepsis awareness often concentrates where it was first trained, leaving general wards less prepared.

Ask for actual time-to-antibiotic data, not a general assurance that treatment is prompt.
Tracked data is the only real evidence of consistent performance.

E-LEARNING academy.gmj.ge/std4-26-sepsis-recognition — 30 min · complete before self-assessment

Standard 4.27 **CORE** · *Standard 4: Care & Treatment*

Pressure Injury Risk Is Assessed and Actively Prevented

ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.27
CORE
L1

THE STANDARD

Pressure Injury Risk Is Assessed and Actively Prevented

Every patient is assessed for pressure injury risk on admission and periodically thereafter, with a specific, documented prevention plan for at-risk patients — repositioning schedules, appropriate surfaces — not addressed only after an injury has already developed.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is every patient assessed for pressure injury risk on admission using a structured tool?** *A validated risk assessment tool, not visual inspection alone.* Doc: Risk assessment tool and completed sample	YES	PARTIAL	NO
2	**Is risk reassessed periodically during a stay, not only at the point of admission?** *Risk can change significantly as a patient's mobility or condition changes during their stay.* Doc: Reassessment schedule and records	YES	PARTIAL	NO
3	**Does a documented, specific prevention plan exist for patients identified as at-risk?** *Specific interventions — repositioning schedule, surface type — not a general awareness the patient is at risk.* Doc: Prevention plan for at-risk patients	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Risk assessment tool review*	Reviews the risk assessment tool used and checks completion consistency, including periodic reassessment, across a sample of admissions.
OBSERVE *Prevention plan implementation check*	Checks whether a specific, visible prevention plan is actually in place for a current at-risk patient.
DOCUMENT *Patient and family education check*	Checks whether at-risk patients and families receive education about pressure injury prevention, as distinct from staff-only awareness.

REFERENCES

[23] *Established patient safety guidance requires systematic risk assessment at admission and periodic reassessment, with a documented, evidence-based prevention plan for identified risks.*

Standard 4.27 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Most pressure injuries are preventable, and the interventions that prevent them are well established and inexpensive — but only if risk is identified early enough for prevention to actually happen, rather than treatment beginning only once damage is already visible.

The evidence [23]: Established patient safety guidance requires systematic risk assessment at admission and periodic reassessment, with a documented, evidence-based prevention plan for identified risks.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured risk assessment happens at admission and is periodically repeated during the stay.	✗ Risk assessment happens once at admission, or not at all, with no periodic reassessment.
✓ A specific, documented prevention plan exists and is visibly followed for at-risk patients.	✗ At-risk patients are identified but no specific prevention plan follows.
✓ Patients and families receive genuine education about prevention, not just staff-facing protocol.	✗ Patients and families receive no education about pressure injury risk or prevention.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Assessment happens reliably at admission but reassessment during longer stays is inconsistent.**
Risk can change substantially over a longer stay, and admission-only assessment misses that shift.

2 **A prevention plan exists but repositioning schedules aren't consistently followed under staffing pressure.**
A documented plan and its consistent execution are different things, especially when short-staffed.

3 **Staff-facing prevention protocol is strong; patient and family education is an afterthought.**
Prevention benefits from an engaged patient and family, not staff vigilance alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current risk assessment practice for consistency and periodic reassessment.

Week 2 Establish or reinforce specific, documented prevention plans for at-risk patients.

Week 3 Build patient and family education into the standard prevention process.

Ongoing Audit reassessment consistency and prevention plan adherence periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check for reassessment specifically, not just an initial admission score.
This is the most common, specific gap in otherwise reasonable practice.

Ask a current at-risk patient or family member what they've been told about prevention.
Patient-side confirmation reveals whether education is genuine, not just documented as delivered.

E-LEARNING academy.gmj.ge/std4-27-pressure-injury — 30 min · complete before self-assessment

Standard 4.28 **CORE** · *Standard 4: Care & Treatment*

VTE Risk Is Assessed Before Every Admission and Procedure

ASSESSMENT
ASF-STD4-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.28
CORE
L1

THE STANDARD

VTE Risk Is Assessed Before Every Admission and Procedure

Every patient is assessed for venous thromboembolism risk at admission and before surgical procedures, with appropriate prophylaxis — pharmacological or mechanical — genuinely prescribed and administered for at-risk patients, not left as a general awareness that blood clots are a possible complication.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every patient assessed for VTE risk at admission using a structured tool?** *A specific, structured assessment, not informal judgement about which patients seem higher risk.* Doc: VTE risk assessment tool and completed sample	YES	PARTIAL	NO
2	**Is risk reassessed before surgical procedures specifically, not only at general admission?** *Surgery itself changes VTE risk, and pre-procedure reassessment catches that shift.* Doc: Pre-procedure reassessment record	YES	PARTIAL	NO
3	**Is appropriate prophylaxis actually prescribed and administered for patients identified as at-risk?** *Identification without follow-through provides no real protection.* Doc: Prophylaxis prescription and administration record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Risk assessment consistency review*	Reviews VTE risk assessment completion at admission and before procedures across a sample of patients.
DOCUMENT *Prophylaxis administration check*	Checks whether identified at-risk patients actually received prescribed prophylaxis, not just an assessment result on file.
ASK *Clinical staff interview*	Asks clinical staff to describe the VTE risk assessment and prophylaxis process for a recent, specific patient.

REFERENCES

[17] *National Institute for Health and Care Excellence. Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. NICE guideline NG89. London: NICE; 2018 — establishes systematic risk assessment and appropriate prophylaxis as standard practice for all applicable hospital admissions.*

Standard 4.28 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Venous thromboembolism is a leading preventable cause of hospital death, and effective prophylaxis is well established, inexpensive, and low-risk relative to the harm it prevents. The gap is almost never a lack of available prevention — it's a missed or skipped risk assessment that never triggers the prevention in the first place.

The evidence [17]: National Institute for Health and Care Excellence. Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. NICE guideline NG89. London: NICE; 2018 — establishes systematic risk assessment and appropriate prophylaxis as standard practice for all applicable hospital admissions.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ VTE risk is assessed consistently at admission and reassessed before procedures.	✗ No structured VTE risk assessment exists beyond general clinical awareness.
✓ Identified at-risk patients consistently receive appropriate, documented prophylaxis.	✗ At-risk patients are identified but prophylaxis is inconsistently prescribed or administered.
✓ Staff can describe the process specifically and confidently for a real recent case.	✗ Reassessment before surgical procedures doesn't happen, relying on the original admission assessment alone.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 Assessment happens reliably for surgical patients but less consistently for medical admissions.
VTE risk awareness is often historically stronger in surgical contexts, leaving medical patients under-assessed.

2 Prophylaxis is prescribed but administration is inconsistently tracked or confirmed.
A prescription that doesn't reliably translate into administration provides no real protection.

3 Mechanical prophylaxis (compression devices) is used inconsistently even when correctly prescribed.
Mechanical measures depend on genuine, ongoing use, which can lapse more easily than a one-time medication dose.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review VTE risk assessment consistency across both surgical and medical admissions.

Week 2 Establish or reinforce pre-procedure reassessment as a distinct, required step.

Week 3 Build a verification step confirming prescribed prophylaxis is actually administered.

Ongoing Audit prophylaxis administration rates periodically against risk assessment results.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check medical admissions specifically, not just surgical ones.
VTE prevention rigor often concentrates in surgical contexts, leaving medical patients under-protected.

Ask to see administration records, not just the prescription.
A prescribed but unadministered prophylaxis is a common, specific gap worth checking directly.

E-LEARNING academy.gmj.ge/std4-28-vte-prophylaxis — 30 min · complete before self-assessment

	Standard 4.29 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **Blood and Blood Products Are Verified Before Every Transfusion**	ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.29
NON-NEGOTIABLE
L1

THE STANDARD

Blood and Blood Products Are Verified Before Every Transfusion

Blood and blood products are matched to the correct patient through an independent two-person verification at the bedside immediately before transfusion, with the reaction monitored throughout — not a single check at collection assumed to hold true all the way to administration.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there an independent two-person verification of blood product and patient identity immediately before transfusion, at the bedside?** *Two people, independently, at the actual point of administration — not a single check earlier in the process.* Doc: Bedside verification protocol and record sample	YES	PARTIAL	NO
2	**Is the patient monitored for a reaction during and immediately after transfusion, on a defined schedule?** *A specific monitoring schedule, not "someone will notice if something goes wrong."* Doc: Transfusion monitoring record	YES	PARTIAL	NO
3	**Is there a defined, immediate response protocol for a suspected transfusion reaction?** *A specific, known process — not improvisation in the moment.*	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Bedside verification observation*	Observes or reviews detailed records of the two-person bedside verification step for a sample of recent transfusions.
DOCUMENT *Monitoring record review*	Reviews transfusion monitoring records for consistency with the defined schedule.
ASK *Reaction response interview*	Asks clinical staff to describe the specific response protocol for a suspected transfusion reaction.

REFERENCES

[1] *Blood transfusion safety standards, including AABB's Standards for Blood Banks and Transfusion Services, require independent two-person bedside verification immediately before administration as a distinct, non-negotiable safeguard separate from earlier collection and crossmatch checks.*

Standard 4.29 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A transfusion error is one of the few clinical mistakes capable of causing severe harm within minutes, and the verification step exists specifically to catch a mismatch introduced anywhere between collection and the bedside — which a single early check cannot do on its own.

The evidence [1]: Blood transfusion safety standards, including AABB's Standards for Blood Banks and Transfusion Services, require independent two-person bedside verification immediately before administration as a distinct, non-negotiable safeguard separate from earlier collection and crossmatch checks.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Independent two-person bedside verification happens consistently, immediately before every transfusion.	✗ Verification happens once at collection, with no independent bedside check before administration.
✓ Monitoring during and after transfusion follows a defined, consistently applied schedule.	✗ Monitoring is informal, with no defined schedule.
✓ Staff describe a specific, confident response protocol for a suspected reaction.	✗ Staff are uncertain what to do if a reaction is suspected.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Bedside verification happens but isn't genuinely independent — the same person effectively checks their own work twice.**
Independent verification requires a second person forming their own judgement, not confirming the first person's.

2 **Monitoring is thorough in the first few minutes but tapers off before the transfusion completes.**
Reactions can occur at any point during administration, not only at the start.

3 **A reaction response protocol exists but hasn't been drilled or reviewed recently.**
An untested protocol may not translate smoothly into fast, confident action in an actual emergency.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent transfusion records for genuine two-person bedside verification.

Week 2 Reinforce genuine independence in the verification process, not sequential confirmation by the same effective judgement.

Week 3 Establish or reinforce a defined, complete monitoring schedule covering the full transfusion period.

Ongoing Periodically review or drill the reaction response protocol with relevant staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask who performed the bedside check and confirm genuine independence.
A specific example reveals whether this is a real second check or a formality.

Ask about monitoring at the end of a transfusion specifically, not just the beginning.
Monitoring discipline commonly tapers off before a transfusion is actually complete.

E-LEARNING academy.gmj.ge/std4-29-blood-products — 30 min · complete before self-assessment

	Standard 4.30 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment* **Handoffs Use a Structured, Verbal Process — Not Just a Written Note**	**ASSESSMENT** *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.30
NON-NEGOTIABLE
L1

THE STANDARD

Handoffs Use a Structured, Verbal Process — Not Just a Written Note

Clinical handoffs between shifts or care teams follow a structured, standardised format delivered verbally with an opportunity to ask questions — not a written note alone that the receiving clinician reads without any live exchange.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Do handoffs follow a structured, standardised format, not an unstructured verbal or written summary?** *A defined structure — covering the same essential elements every time, not left to individual habit.* Doc: Handoff format template	YES	PARTIAL	NO
2	**Is the handoff delivered live and verbally, with an opportunity for the receiving clinician to ask questions?** *Live exchange, not a written note read in isolation with no chance to clarify.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is the handoff process consistent across shift changes and between departments, not only within one team's habit?** *Consistency matters most exactly at the boundaries where information is most likely to be lost.* Doc: Cross-department handoff consistency check	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Live handoff observation*	Observes an actual shift handoff for structure, verbal delivery, and genuine opportunity for questions.
DOCUMENT *Format template review*	Reviews the standardised handoff format for completeness and consistent use.
ASK *Cross-department consistency interview*	Asks staff in different departments to describe their handoff process, checking for genuine consistency.

REFERENCES

Correct patient identification and effective communication are named together among JCI's International Patient Safety Goals, with structured handoff communication specifically identified as a distinct requirement from general clinical documentation.

Standard 4.30 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A written note can be misread, skimmed, or simply not reach the right person in time; a live, structured verbal handoff with a chance to ask questions catches ambiguity and missing information in the moment, before it becomes a gap in care.

The evidence: Correct patient identification and effective communication are named together among JCI's International Patient Safety Goals, with structured handoff communication specifically identified as a distinct requirement from general clinical documentation.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Handoffs consistently follow a structured, standardised format, delivered live and verbally.	✗ Handoffs are written notes only, with no live verbal exchange.
✓ The receiving clinician has a genuine, used opportunity to ask questions.	✗ No standardised structure exists; content varies significantly by who is handing over.
✓ The process is consistent across shifts and departments, not dependent on individual team habit.	✗ Different departments have noticeably inconsistent handoff practices.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A structured format exists for nursing handoffs but not for physician-to-physician handoffs.**
Different professional groups sometimes develop separate, uncoordinated handoff cultures within the same facility.

2 **Verbal handoff happens but questions are rarely actually asked, suggesting limited genuine engagement.**
The opportunity existing and being genuinely used are different things worth checking separately.

3 **Handoff quality is strong during weekday daytime shifts but thinner at night or on weekends.**
Staffing and time pressure at less-supervised times often erode structured processes first.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current handoff practice across different shifts and departments for structure and consistency.

Week 2 Adopt or reinforce a standardised handoff format applied across all relevant staff groups.

Week 3 Brief staff explicitly on the expectation of live, verbal delivery with genuine opportunity for questions.

Ongoing Spot-check handoff quality periodically, particularly at night and on weekends.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual handoff, don't just review the template.
Live observation reveals whether structure exists in practice, not only on paper.

Check physician handoffs specifically, not only nursing handoffs.
Structured handoff culture sometimes takes hold in one professional group and not others.

E-LEARNING academy.gmj.ge/std4-30-structured-handoff — 30 min · complete before self-assessment

	Standard 4.31 **CORE** · *Standard 4: Care & Treatment* **Opioid Prescribing Is Deliberately Stewarded**	**ASSESSMENT** *ASF-STD4-v3.0*

CR ADAPTED	**TR** ADAPTED	**SM** FULL	**ST** FULL

4.31
CORE
L1

THE STANDARD

Opioid Prescribing Is Deliberately Stewarded

Opioid prescribing follows a defined stewardship approach — appropriate dose and duration, genuine consideration of non-opioid alternatives, and monitoring for signs of diversion or misuse — led by a trained, designated person or a physician champion where no dedicated pharmacy function exists, not treated identically to any other medication once high-alert safeguards are satisfied.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a defined stewardship approach for opioid prescribing, distinct from general high-alert medication management?** *Specific to opioids — dose, duration, alternatives — not folded generically into broader medication safety.* Doc: Opioid stewardship protocol	YES	PARTIAL	NO
2	**Are non-opioid alternatives genuinely considered and documented before opioid prescribing, not just theoretically available?** *Evidence of actual consideration, not an assumption that alternatives were weighed.* Doc: Prescribing documentation sample	YES	PARTIAL	NO
3	**Is there monitoring for signs of diversion or misuse, not just appropriate initial prescribing?** *Stewardship extends beyond the prescribing moment into ongoing awareness.* Doc: Diversion monitoring process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Stewardship protocol review*	Reviews the specific opioid stewardship protocol for dose, duration, and alternative-consideration guidance.
DOCUMENT *Prescribing documentation check*	Reviews a sample of opioid prescriptions for documented consideration of non-opioid alternatives.
ASK *Diversion monitoring interview*	Asks pharmacy or nursing staff to describe how diversion or misuse concerns are identified and addressed.

REFERENCES

[7] *Established clinical practice guidance for prescribing opioids for pain establishes dose, duration, and alternative-consideration principles as core opioid stewardship practice, reflected in guidance recognized across many countries.*

Standard 4.31 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Opioid harm operates on a different timescale and pattern than most medication safety risk — the danger isn't only an acute administration error, but a slower, cumulative risk of dependency, diversion, and long-term harm that a standard high-alert medication check doesn't specifically address. Stewardship is a genuine, ongoing function, and where a facility has no pharmacy department to lead it, a specifically designated physician or senior clinician can perform this role exactly as validly.

The evidence [7]: Established clinical practice guidance for prescribing opioids for pain establishes dose, duration, and alternative-consideration principles as core opioid stewardship practice, reflected in guidance recognized across many countries.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific opioid stewardship protocol exists, distinct from general medication safety practice.	✗ Opioids are managed identically to other high-alert medications, with no opioid-specific stewardship approach.
✓ Non-opioid alternatives are genuinely considered and documented, not just theoretically available.	✗ No documentation shows alternatives were considered before opioid prescribing.
✓ A real monitoring process exists for diversion or misuse concerns.	✗ No monitoring exists for diversion or misuse beyond initial prescribing safeguards.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Stewardship principles are followed by senior prescribers but less consistently by covering or junior staff.**
Institutional knowledge doesn't always transfer without deliberate, structured reinforcement.

2 **Alternatives are considered clinically but not documented, making the practice hard to verify or audit.**
Genuine practice that isn't documented can't be reliably distinguished from practice that didn't happen.

3 **Diversion monitoring exists for inpatient settings but not for discharge prescriptions.**
Diversion risk doesn't end at discharge, and monitoring that stops there misses a real ongoing risk period.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current opioid prescribing documentation for evidence of alternative consideration.

Week 2 Establish or reinforce a specific opioid stewardship protocol, distinct from general medication safety.

Week 3 Build a monitoring process for diversion or misuse signs, covering discharge prescriptions specifically.

Ongoing Audit prescribing documentation and monitoring practice periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the opioid-specific protocol, not general high-alert medication policy.
A facility without a distinct opioid protocol likely hasn't genuinely separated this risk category yet.

Ask about discharge prescription monitoring specifically.
This is where diversion risk monitoring most commonly stops, even when inpatient practice is strong.

Ask who leads opioid stewardship at this facility, and accept a named physician champion as a genuine answer.
The absence of a pharmacy department is not, on its own, evidence stewardship is missing — the presence of a genuinely designated, trained owner is what matters.

E-LEARNING academy.gmj.ge/std4-31-opioid-stewardship — 30 min · complete before self-assessment

	Standard 4.32 **CORE** · *Standard 4: Care & Treatment* **Pain Is Formally Assessed and Reassessed, Not Just Asked About Once**	**ASSESSMENT** *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.32
CORE
L1

THE STANDARD

Pain Is Formally Assessed and Reassessed, Not Just Asked About Once

Every patient's pain is assessed using a structured tool on admission and reassessed at defined intervals, particularly after any intervention intended to address it — not asked about once informally and left unrevisited.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is pain assessed using a structured tool on admission, not an informal, unstructured question?** *A specific, structured scale appropriate to the patient, not a general "how are you feeling" check.* Doc: Pain assessment tool and completed sample	YES	PARTIAL	NO
2	**Is pain reassessed at defined intervals, particularly after any intervention intended to address it?** *Reassessment specifically tied to interventions, not just a general periodic check.* Doc: Reassessment record	YES	PARTIAL	NO
3	**Are reassessment results actually used to adjust the care plan, not just recorded and left unactioned?** *A reassessment that doesn't influence care provides no real benefit over not reassessing at all.* Doc: Care plan adjustment record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Assessment tool review*	Reviews the pain assessment tool used and checks completion consistency on admission.
DOCUMENT *Reassessment timing review*	Reviews whether reassessment specifically follows pain-related interventions, not only a general schedule.
OBSERVE *Care plan responsiveness check*	Checks whether reassessment results are reflected in actual adjustments to the care plan.

REFERENCES

Formal pain assessment and reassessment is an established element of patient-centred care standards in major hospital accreditation frameworks internationally, treated as its own distinct requirement rather than folded into general clinical assessment.

Standard 4.32 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Unaddressed pain affects recovery, mobility, and a patient's ability to participate in their own care, and a one-time informal check misses both the patients whose pain wasn't adequately captured at that single moment and any change in pain after treatment was given.

The evidence: Formal pain assessment and reassessment is an established element of patient-centred care standards in major hospital accreditation frameworks internationally, treated as its own distinct requirement rather than folded into general clinical assessment.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Pain is assessed using a structured tool on admission, consistently.	✗ Pain is asked about informally once, with no structured tool used.
✓ Reassessment specifically follows interventions intended to address pain.	✗ No reassessment happens after interventions intended to address pain.
✓ Reassessment results are visibly used to adjust the care plan, not just recorded.	✗ Reassessment results are documented but never lead to any change in the care plan.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Assessment is structured and thorough at admission but reassessment becomes informal or inconsistent afterward.**
Initial assessment often receives more deliberate attention than the ongoing reassessment that follows.

2 **A structured tool is used but not adapted for patients who can't self-report clearly, such as those who are cognitively impaired.**
A tool that works well for most patients can still leave a meaningful group without adequate assessment.

3 **Reassessment happens and is documented but rarely results in a visible care plan change.**
Documentation without responsive action provides limited real benefit to the patient.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current pain assessment practice for structured tool use and reassessment consistency.

Week 2 Ensure the assessment tool is adapted for patients who cannot self-report clearly.

Week 3 Establish reassessment specifically tied to interventions, not only a general schedule.

Ongoing Audit whether reassessment results are actually reflected in care plan adjustments.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check reassessment specifically after an intervention, not just admission assessment.
This is the most common gap — strong initial assessment, weak follow-through.

Ask how pain is assessed for a patient who cannot self-report clearly.
This reveals whether the tool genuinely covers the whole patient population, not just the straightforward cases.

E-LEARNING academy.gmj.ge/std4-32-pain-management — 30 min · complete before self-assessment

Standard 4.33 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Dignity, Respect, and Non-Discrimination Are Practised, Not Just Stated

ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.33
NON-NEGOTIABLE
L1

THE STANDARD

Dignity, Respect, and Non-Discrimination Are Practised, Not Just Stated

Every patient is treated with dignity and respect regardless of background, and care decisions are demonstrably free of discrimination based on race, religion, gender, disability, sexual orientation, or any other protected characteristic — verified through observation and patient experience, not assumed from a written policy.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a written non-discrimination policy covering care decisions, not only administrative or employment matters?** *Specifically covering clinical care and treatment decisions, not just a general workplace policy.* Doc: Non-discrimination policy document	YES	PARTIAL	NO
2	**Can staff describe specific ways they ensure equitable treatment across different patient backgrounds?** *Concrete, specific practices, not a general assurance that discrimination doesn't happen here.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a mechanism for a patient to report perceived discriminatory treatment, distinct from a general complaint process?** *A pathway that specifically names and takes discrimination concerns seriously, not folded anonymously into general feedback.* Doc: Discrimination-specific reporting mechanism	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Policy scope review*	Reviews the non-discrimination policy for coverage of clinical care decisions specifically, not only administrative matters.
ASK *Staff practice interview*	Asks staff to describe specific, concrete practices ensuring equitable treatment across patient backgrounds.
OBSERVE *Patient experience check*	Where possible, observes or gathers patient feedback on whether treatment felt equitable and respectful across different backgrounds.

REFERENCES

Non-discrimination and equitable treatment are foundational patient rights principles across international healthcare quality frameworks, consistently requiring verification through actual patient experience and observed practice, not policy existence alone.

Standard 4.33 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A non-discrimination policy that exists only on paper protects nobody. This has to be verified through how patients are actually treated and what they actually experience, because discrimination in healthcare is rarely announced — it shows up in subtler differences in attention, explanation, and respect that a policy document cannot catch.

The evidence: Non-discrimination and equitable treatment are foundational patient rights principles across international healthcare quality frameworks, consistently requiring verification through actual patient experience and observed practice, not policy existence alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A non-discrimination policy specifically covers clinical care decisions, not only administrative matters.	✗ Policy exists only for employment matters, silent on clinical care decisions.
✓ Staff describe concrete, specific practices, not general assurances.	✗ Staff can only offer general assurances with no specific practice examples.
✓ A discrimination-specific reporting mechanism exists, distinct from general complaints.	✗ No distinct mechanism exists for reporting discriminatory treatment; it would be lost in general feedback.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Policy exists and is comprehensive but was never specifically communicated to clinical staff.**
A well-written policy that never reaches the people making care decisions has limited practical effect.

2 **Staff describe good intentions but struggle to give specific examples of how equity is actually ensured.**
Genuine practice usually shows in specific examples; general intentions alone are harder to verify.

3 **A reporting mechanism exists but few patients know it's available or specifically covers discrimination.**
Availability that isn't communicated functions similarly to unavailability.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current policy scope for coverage of clinical care decisions specifically.

Week 2 Communicate the policy directly to clinical staff, with concrete examples of equitable practice.

Week 3 Establish a distinct, clearly communicated mechanism for reporting discrimination concerns.

Ongoing Gather patient feedback periodically specifically addressing equitable treatment.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff for a specific example, not a general assurance.
Concrete practice examples distinguish genuine internalisation from stated policy.

Ask how a patient would report a discrimination concern specifically, not a general complaint.
A distinct, known pathway is the real evidence this is taken seriously as its own category.

E-LEARNING academy.gmj.ge/std4-33-dignity-non-discrimination — 30 min · complete before self-assessment

	Standard 4.34 NON-NEGOTIABLE · *Standard 4: Care & Treatment* **Vulnerable Patients Get Real, Specific Protections**	ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.34
NON-NEGOTIABLE
L1

THE STANDARD

Vulnerable Patients Get Real, Specific Protections

Patients who are elderly, cognitively impaired, or otherwise vulnerable to reduced capacity for self-advocacy receive specific, documented additional protections — not the same general care approach applied to every patient regardless of their actual ability to protect their own interests.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a process to identify patients with reduced capacity for self-advocacy, not left to informal staff judgement alone?** *A specific, structured identification process, not assumed to be obvious.* Doc: Vulnerability identification process	YES	PARTIAL	NO
2	**Do identified vulnerable patients receive specific, documented additional protections?** *Concrete, named protections — not the same general care approach applied to everyone.* Doc: Additional protections documentation	YES	PARTIAL	NO
3	**Is there a designated advocate or process ensuring a vulnerable patient's interests are actively represented in care decisions?** *Active representation, not an assumption that standard processes adequately protect everyone equally.* Doc: Advocate or representation process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Identification process review*	Reviews the process for identifying patients with reduced capacity for self-advocacy.
DOCUMENT *Additional protections check*	Reviews documentation for specific, additional protections applied to identified vulnerable patients.
ASK *Advocacy process interview*	Asks staff to describe how a vulnerable patient's interests are actively represented in a specific, real care decision.

REFERENCES

Vulnerable patient protection frameworks, addressing populations with reduced capacity for self-advocacy, are established requirements across major international healthcare quality and safety standards, distinct from general patient rights provisions.

Standard 4.34 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A patient who cannot easily advocate for themselves — through age, cognitive impairment, or another factor — is at higher risk of having needs overlooked, decisions made without adequate involvement, or subtle neglect go unnoticed precisely because they're less able to raise concerns. Specific protections exist because equal treatment isn't the same as equitable treatment when starting capacity differs.

The evidence: Vulnerable patient protection frameworks, addressing populations with reduced capacity for self-advocacy, are established requirements across major international healthcare quality and safety standards, distinct from general patient rights provisions.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, structured process identifies patients with reduced capacity for self-advocacy.	✗ No specific identification process exists beyond informal staff impression.
✓ Identified patients receive specific, documented additional protections beyond standard care.	✗ Vulnerable patients receive the same general approach as any other patient, with no additional protections.
✓ A real advocacy or representation process ensures active involvement in care decisions.	✗ No advocacy or representation process exists for patients unable to fully self-advocate.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 Identification happens for obviously impaired patients but misses more subtle or intermittent vulnerability.
Capacity can fluctuate or be less visibly apparent, and a process calibrated for obvious cases misses this.

2 Additional protections exist on paper but aren't consistently implemented in daily practice.
A protection that exists as policy but not as lived practice provides limited real benefit.

3 An advocacy process exists for family-involved patients but not for those without present family or support.
Patients without accompanying family or support are often the ones most in need of a facility-provided advocate.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for identifying patients with reduced self-advocacy capacity.

Week 2 Establish specific, documented additional protections for identified vulnerable patients.

Week 3 Build an advocacy or representation process, with particular attention to patients without present family support.

Ongoing Audit identification and protection consistency periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about a patient with no accompanying family or support specifically.
This is where advocacy processes are most likely to have a genuine, unaddressed gap.

Ask for a specific, real example of additional protections being applied.
A concrete example reveals genuine practice better than a description of policy.

E-LEARNING academy.gmj.ge/std4-34-vulnerable-patients — 30 min · complete before self-assessment

Standard 4.35 **CORE** · *Standard 4: Care & Treatment*

Advance Directives Are Sought, Documented, and Actually Followed

ASSESSMENT *ASF-STD4-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

4.35
CORE
L1

THE STANDARD

Advance Directives Are Sought, Documented, and Actually Followed

Patients are asked about existing advance directives and offered support to create one where appropriate, with any documented directive genuinely accessible to the care team and followed — not asked once as a formality with no real mechanism ensuring it influences actual care decisions.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are patients asked about existing advance directives as part of standard admission practice?** *A routine, standard question, not asked inconsistently or only when a situation prompts it.* Doc: Admission process documentation	YES	PARTIAL	NO
2	**Is a documented advance directive genuinely accessible to the care team at the point of an actual decision?** *Findable in the moment it matters, not filed somewhere nobody checks during an emergency.* Doc: Directive accessibility check	YES	PARTIAL	NO
3	**Is there evidence that documented directives actually influence care decisions when relevant?** *Genuine adherence, not just documentation that exists but goes unconsulted.* Doc: Directive adherence record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Admission practice review*	Reviews whether advance directive questions are a consistent, standard part of admission practice.
OBSERVE *Accessibility check*	Checks how quickly and reliably a documented advance directive can actually be located by a care team member.
DOCUMENT *Adherence record review*	Reviews cases where a directive existed to check whether it was genuinely followed in the relevant care decision.

REFERENCES

Advance care planning and directive documentation is an established element of patient-centred care and end-of-life care quality frameworks internationally, with genuine accessibility and adherence identified as distinct requirements from the initial documentation step.

Standard 4.35 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

An advance directive that exists in a file nobody checks during an actual emergency provides no real protection of a patient's wishes. The value of asking the question depends entirely on the answer being findable and genuinely honoured at the moment it matters.

The evidence: Advance care planning and directive documentation is an established element of patient-centred care and end-of-life care quality frameworks internationally, with genuine accessibility and adherence identified as distinct requirements from the initial documentation step.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Advance directive questions are a consistent, standard part of every admission.	✗ Advance directive questions are asked inconsistently or only in specific situations.
✓ Documented directives are genuinely, quickly accessible to the care team when needed.	✗ Directives are documented but difficult or slow to locate during an actual care decision.
✓ Real evidence exists that directives influence actual care decisions, not just sit on file.	✗ No evidence exists that documented directives have influenced any real care decision.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **The question is asked consistently but support to actually create a directive isn't offered.**
Asking whether one exists is different from helping a patient who wants one but doesn't have one yet.

2 **Directives are documented but stored in a system not all relevant staff can quickly access.**
Documentation that isn't genuinely accessible at the point of decision provides limited real protection.

3 **Directives are respected when family is present to remind staff but not consistently otherwise.**
Reliance on family prompting rather than a systematic accessibility process leaves a real gap.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current admission practice for consistency of advance directive questions.

Week 2 Ensure genuine support is offered to patients who want to create a directive.

Week 3 Verify and improve directive accessibility to all relevant care team members, not dependent on family reminders.

Ongoing Review real cases periodically to confirm directives are actually influencing care decisions.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Test how quickly a documented directive can actually be located.
Accessibility in practice, not just documentation existing somewhere, is the real test.

Ask about a case where a directive existed and trace what actually happened.
A real example reveals genuine adherence better than a description of the intended process.

E-LEARNING academy.gmj.ge/std4-35-advance-directives — 30 min · complete before self-assessment

Standard 4.36 **CORE** · *Standard 4: Care & Treatment*

The Facility Tracks Its Own Infection Rate Over Time

ASSESSMENT *ASF-STD4-v3.0*

CR N/A	TR ADAPTED	SM ADAPTED	ST FULL

4.36
CORE
L1

THE STANDARD

The Facility Tracks Its Own Infection Rate Over Time

The facility measures and trends its own healthcare-associated infection rate as a standing indicator, reviewed regularly — not only following individual prevention bundles like surgical site infection practice, without ever stepping back to see whether the overall rate is actually improving.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the facility measure its own healthcare-associated infection rate, not only comply with individual prevention practices?** *A real, tracked number specific to this facility, not an assumption that following the bundles is sufficient on its own.* Doc: Infection rate surveillance data	YES	PARTIAL	NO
2	**Is the rate trended over time and reviewed on a regular schedule, not calculated once and left unexamined?** *A single measurement doesn't show a trend; regular review is what reveals whether prevention practice is actually working.* Doc: Trend review schedule and record	YES	PARTIAL	NO
3	**Does the facility know whether its rate is improving, worsening, or unchanged, and can it say why?** *Genuine engagement with what the data shows, not data collected and filed without interpretation.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Surveillance data review*	Reviews the facility's own infection rate tracking data for consistency and completeness over time.
DOCUMENT *Trend review schedule check*	Checks whether the rate is reviewed on a regular, defined schedule, not calculated once.
ASK *Data interpretation interview*	Asks infection prevention staff to describe the facility's current trend and what, if anything, has changed in response to it.

REFERENCES

Healthcare-associated infection surveillance and trending is a distinct, established requirement in international infection prevention frameworks, recognised as necessary alongside — not replaced by — individual prevention bundle compliance.

Standard 4.36 · *Standard 4: Care & Treatment*

Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

Following good infection prevention practices and knowing whether they're actually working are different things. A facility can faithfully run every prevention bundle in this document and still not know if its real infection rate is going up, down, or staying flat, because nobody is tracking the number itself over time.

The evidence: Healthcare-associated infection surveillance and trending is a distinct, established requirement in international infection prevention frameworks, recognised as necessary alongside — not replaced by — individual prevention bundle compliance.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A real infection rate is measured and tracked specifically for this facility. ✓ The rate is trended over time and reviewed on a defined, regular schedule. ✓ Staff can describe the current trend and any changes made in response to it.	✗ No facility-specific infection rate is measured; prevention bundle compliance is assumed to be sufficient on its own. ✗ A rate was calculated once, historically, with no ongoing trend tracking. ✗ Staff cannot describe whether the facility's rate is improving, worsening, or unchanged.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Data is collected but not reviewed on a consistent schedule, so trends are noticed late if at all.**
Collection without regular review provides limited real early-warning value.

2 **The rate is tracked for surgical site infections specifically but not more broadly across other infection types.**
A narrower scope than the facility's actual infection risk profile can miss a genuine emerging problem elsewhere.

3 **Data is reviewed by infection prevention staff but not shared with the wider clinical team or governance structure.**
A trend that stays within one department has less power to drive facility-wide improvement.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Establish what infection data the facility currently has, even informally, and identify gaps.

Week 2 Build a simple, consistent method for tracking the facility's own rate over time.

Week 3 Establish a regular review schedule, even monthly, for examining the trend.

Ongoing Share trend data with the wider clinical team and governance structure, not only infection prevention staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the actual trend data, not a description of prevention bundles in use.
This criterion is specifically about knowing the outcome, not just following the process.

Ask whether the rate has changed recently and why, testing genuine engagement with the data.
A real, considered answer reveals whether the data is actually being used, not just collected.

E-LEARNING academy.gmj.ge/std4-36-hai-surveillance — 30 min · complete before self-assessment

Standard 4.37 **NON-NEGOTIABLE** · *Standard 4: Care & Treatment*

Medication Safety Doesn't Depend on Software That Isn't Actually Working

ASSESSMENT *ASF-STD4-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

4.37
NON-NEGOTIABLE
L1

THE STANDARD

Medication Safety Doesn't Depend on Software That Isn't Actually Working

Where an electronic system is used for medication safety checks — drug interactions, allergy alerts, duplicate therapy — its actual function is verified and audited, not assumed from its presence, and where records are split between paper and electronic, one is clearly designated as the record staff check first, so the two can never silently disagree about what a patient is actually taking.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**If your electronic system claims to check for drug interactions, allergies, or duplicate therapy, has this actually been tested and confirmed to work — not assumed from the system's marketing or original configuration?** *A specific test — entering a known interacting pair and confirming an alert fires — not an assumption the feature works because it was purchased.* Doc: Test record or verification log	YES	PARTIAL	NO
2	**If safety checks are not confirmed working, or don't exist, is there a specific manual backup step staff genuinely use instead?** *A defined paper checklist or verbal double-check, not an informal hope that staff will individually remember to be careful.* Doc: Manual backup process documentation	YES	PARTIAL	NO
3	**Where records are split between paper and electronic — common during power instability — is one specific version designated as what staff check first, avoiding the two silently disagreeing?** *A named, consistent rule, not left to individual staff judgement about which version to trust in the moment.* Doc: Record authority designation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Alert function test review*	Reviews evidence that electronic safety alerts have been specifically tested with a known trigger case, not assumed functional.
OBSERVE *Manual backup process check*	Checks whether a genuine, used manual backup exists for any safety check not

	confirmed working electronically.
ASK *Record authority interview*	Asks staff which record — paper or electronic — they check first when both exist for the same patient, testing for a consistent, shared answer.

REFERENCES

[18] *Olakotan OO, Mohd Yusof M. The appropriateness of clinical decision support systems alerts in supporting clinical workflows: a systematic review. Health Informatics J. 2021;27(2):14604582211007536 — documents that clinicians routinely silence, disable, or ignore inappropriate or excessive alerts, meaning an alert's presence in a system does not confirm it is functioning as clinical staff believe.*

Kruse CH, Smith MTD, Clarke DL. Hybrid electronic record: an error reduction strategy for diverse medical prescription formats. S Afr Fam Pract. 2024;66(1):5845 — comparing electronic, tick-sheet, ink-stamp, and handwritten prescribing across real hospitals, found that increasing technology alone did not reduce prescription error rates, but that regular audits, applicable to any format, were the effective error-reduction strategy.

Standard 4.37 · *Standard 4: Care & Treatment*
Guidance & Learning

GUIDANCE
ASF-STD4-v3.0

WHY THIS STANDARD EXISTS

A hospital with software that appears to check for drug interactions but was never configured to do so, or whose alerts have been silenced due to excessive false positives, is in some ways more dangerous than a facility with no electronic system at all — because staff trust a check that isn't actually happening. Separately, unstable power supply commonly forces a mix of paper and electronic records, and when nobody has designated which one is authoritative, the two can quietly diverge without anyone noticing until a patient is harmed by the difference.

The evidence [18]: Olakotan OO, Mohd Yusof M. The appropriateness of clinical decision support systems alerts in supporting clinical workflows: a systematic review. Health Informatics J. 2021;27(2):14604582211007536 — documents that clinicians routinely silence, disable, or ignore inappropriate or excessive alerts, meaning an alert's presence in a system does not confirm it is functioning as clinical staff believe.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Electronic safety alerts have been specifically tested and confirmed to function, with dated verification records.	✗ Electronic alerts are assumed functional because the software was purchased with that feature, never actually tested.
✓ A genuine, used manual backup exists for any check not confirmed working.	✗ No manual backup exists for safety checks the electronic system doesn't reliably perform.
✓ Staff give a consistent, immediate answer about which record is authoritative when paper and electronic both exist.	✗ Different staff give different answers about which record — paper or electronic — is authoritative, or seem uncertain.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 The system was tested once at installation but never re-verified after an update or configuration change.
Software updates can silently disable or alter alert behaviour without anyone noticing until it's tested again.

2 A manual backup exists for the most obvious checks but not for less prominent ones, like duplicate therapy.
Attention naturally concentrates on the most dramatic risk category, leaving quieter but still real gaps uncovered.

3 Record authority is clear to senior staff but not consistently understood by newer or covering staff.
A rule that lives in institutional memory rather than written policy doesn't reliably reach everyone who needs it.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Test every electronic safety alert your system claims to have, using a known trigger case for each.

Week 2 For any check that fails or doesn't exist, establish a specific, written manual backup process.

Week 3 Designate, in writing, which record is authoritative when paper and electronic both exist, and brief all staff.

Ongoing Re-test alert function after any system update, and audit prescriptions periodically against actual records, not assumed accuracy.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual test — a specific trigger case and its result — not a description of the system's features.
A feature list from a vendor brochure is not evidence the feature is confirmed working at this facility.

Ask two different staff members, separately, which record is authoritative.
Inconsistent answers reveal a real, dangerous gap that a single confident answer from one person would hide.

E-LEARNING academy.gmj.ge/std4-37-software-reliability — 30 min · complete before self-assessment

STANDARD 5

Safety & Emergency Preparedness

MANDATORY

6 criteria

	Standard 5.1 NON-NEGOTIABLE · *Standard 5: Safety & Emergency Preparedness* **Triage Actually Sorts Patients by Urgency**	ASSESSMENT *ASF-STD5-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

5.1
NON-NEGOTIABLE
L1

THE STANDARD

Triage Actually Sorts Patients by Urgency

A structured triage system using a validated, internationally recognised urgency scale — such as the Manchester Triage System, the Canadian Triage and Acuity Scale, or an equivalent validated tool — prioritises patients by clinical urgency, used consistently for every arriving patient, not applied selectively based on how busy the department is.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a validated, internationally recognised triage scale used, not an informal or home-grown urgency judgement?** *A named, validated tool — Manchester Triage System or equivalent — not individual staff discretion alone.* Doc: Triage scale documentation and completed sample	YES	PARTIAL	NO
2	**Does every triage nurse or staff member use the same scale consistently, not a personal variation of it?** *Consistency across staff is what makes the scale meaningful as a system, not just a suggestion.* Doc: Staff training record on the specific scale used	YES	PARTIAL	NO
3	**Is the assigned urgency category documented for every patient, with the maximum wait time it implies?** *A category without a documented, implied wait time doesn't translate into an actual commitment to the patient.* Doc: Documented urgency category and wait time sample	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Scale validation review*	Reviews which triage scale is in use and confirms it is a validated, named system, not an informal internal variation.
OBSERVE *Live triage consistency check*	Observes triage being performed by different staff members, checking for consistent application of the same scale.
ASK *Staff scale familiarity interview*	Asks triage staff to name the scale in use and describe how a specific recent case was categorised.

REFERENCES

[16] *The Manchester Triage System, the Canadian Triage and Acuity Scale, the Australasian Triage Scale, and the Emergency Severity Index are the four most internationally established validated triage scales, each using a defined five-level urgency classification with documented reliability and predictive validity for patient outcomes.*

Standard 5.1 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE
ASF-STD5-v3.0

WHY THIS STANDARD EXISTS

Triage exists specifically for the moments it's hardest to do properly — when the department is overwhelmed. A system only used consistently when things are quiet provides no protection during the exact conditions it was built for. A validated scale matters because an informal, home-grown urgency judgement varies significantly between staff members, while a validated tool has been tested for consistency and predictive accuracy.

The evidence [16]: The Manchester Triage System, the Canadian Triage and Acuity Scale, the Australasian Triage Scale, and the Emergency Severity Index are the four most internationally established validated triage scales, each using a defined five-level urgency classification with documented reliability and predictive validity for patient outcomes.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A validated, named triage scale is used consistently by every staff member performing triage.	✗ Triage relies on individual clinical judgement without reference to any named, validated scale.
✓ Urgency categories are documented for every patient with their implied maximum wait time.	✗ Different staff members apply visibly different standards for the same presenting complaint.
✓ Staff can name the scale and describe their reasoning for a real recent categorisation confidently.	✗ Urgency categories, if assigned, aren't documented or linked to any specific wait time commitment.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A validated scale is used by senior triage nurses but newer or covering staff sometimes default to informal judgement.**
Formal training on a specific scale needs to reach everyone who performs triage, not just the most experienced staff.

2 **The scale is used correctly for common presentations but less reliably for less familiar or atypical ones.**
Validated scales are designed for exactly this consistency, but familiarity with common cases can make staff over-confident with unusual ones.

3 **Categorisation happens but isn't consistently re-checked if a patient's condition changes while waiting.**
Triage is a snapshot at arrival; a patient can deteriorate while waiting, and only reassessment catches that.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Confirm which triage approach is currently used and whether it is a validated, named scale.

Week 2 Adopt a validated scale if none is currently in use, and train all staff who perform triage.

Week 3 Establish consistent documentation of assigned urgency category and implied wait time for every patient.

Ongoing Periodically observe triage practice across different staff members to confirm consistent application.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name the specific scale, not just describe general urgency sorting.
A facility genuinely using a validated scale can name it immediately; one relying on informal judgement usually cannot.

Observe triage by more than one staff member if possible.
Consistency across individuals is the real test of whether a scale is genuinely standardising practice.

E-LEARNING academy.gmj.ge/std5-1-triage — 30 min · complete before self-assessment

	Standard 5.2 **NON-NEGOTIABLE** · *Standard 5: Safety & Emergency Preparedness* **Resuscitation Equipment Is Ready Right Now**	**ASSESSMENT** *ASF-STD5-v3.0*

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

5.2
NON-NEGOTIABLE
L1

THE STANDARD

Resuscitation Equipment Is Ready Right Now

Resuscitation equipment is checked every shift, fully stocked and functional, and staff maintaining life support competency are genuinely current, not overdue for recertification.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is resuscitation equipment checked every shift, with a documented record?** *Not checked "regularly" — checked every single shift, verifiably.* Doc: Shift check log	YES	PARTIAL	NO
2	**Is all equipment found fully stocked and functional at each check, with gaps immediately addressed?** *A check that finds gaps but doesn't trigger immediate resupply provides only partial protection.* Doc: Gap resolution record	YES	PARTIAL	NO
3	**Are all relevant staff current on life support certification, not overdue?** *A lapsed certification discovered only during an emergency is a preventable failure.* Doc: Certification tracking record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Shift check log review*	Reviews shift check logs for consistency and completeness across a representative time period.
OBSERVE *Live equipment check*	Directly inspects resuscitation equipment for stock completeness and functionality at the time of assessment.
DOCUMENT *Certification currency check*	Reviews staff certification records for any lapsed or soon-to-lapse life support credentials.

REFERENCES

Resuscitation readiness protocols, including scheduled equipment checks and current life-support certification, are foundational elements of resuscitation system quality frameworks across international emergency care guidance.

Standard 5.2 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE
ASF-STD5-v3.0

WHY THIS STANDARD EXISTS

Resuscitation equipment has exactly one moment where its readiness matters, and there's no opportunity to discover a gap and fix it in the moment. A shift-check routine that's actually followed is the only mechanism that catches a problem before it costs a life.

The evidence: Resuscitation readiness protocols, including scheduled equipment checks and current life-support certification, are foundational elements of resuscitation system quality frameworks across international emergency care guidance.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Shift checks are documented consistently, every shift, with no gaps.	✗ Shift check logs show gaps or inconsistent completion.
✓ Equipment is fully stocked and functional at the point of assessment.	✗ Equipment found during assessment has missing or expired components.
✓ All relevant staff hold current, unexpired life support certification.	✗ One or more staff members have lapsed certification without a tracked renewal plan.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Checks happen consistently during day shifts but less reliably overnight.**
Staffing levels and supervision often differ by shift, and routine tasks can erode accordingly.

2 **Equipment is checked but gaps found aren't always resolved before the next shift.**
Detection without immediate resolution leaves a real gap in coverage.

3 **Certification tracking exists but renewal reminders aren't proactive.**
A system that only notices a lapse after it happens provides no advance protection.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit shift check log completeness across all shifts, including overnight.

Week 2 Establish an immediate resolution process for any gap found during a check.

Week 3 Build a proactive certification renewal tracking and reminder system.

Ongoing Spot-check equipment readiness and certification currency periodically, unannounced.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check overnight and weekend logs specifically, not just weekday daytime records.
Coverage gaps concentrate in less-supervised shifts.

Physically inspect equipment yourself rather than relying on the log alone.
A completed log entry and genuinely current equipment aren't always the same thing.

E-LEARNING academy.gmj.ge/std5-2-resuscitation-readiness — 30 min · complete before self-assessment

Standard 5.3 **NON-NEGOTIABLE** · *Standard 5: Safety & Emergency Preparedness*

There's a Real Disaster Response Plan

ASSESSMENT *ASF-STD5-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

5.3
NON-NEGOTIABLE
L1

THE STANDARD

There's a Real Disaster Response Plan

A mass casualty and disaster response plan exists and has actually been practised through a drill, not written once and filed without ever being tested.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does a documented mass casualty and disaster response plan exist?** *Specific to mass casualty and disaster scenarios, not a general emergency policy.* Doc: Disaster response plan document	YES	PARTIAL	NO
2	**Has the plan actually been practised through a drill, not just written and filed?** *An unrehearsed plan's real-world gaps are unknown until an actual disaster reveals them.* Doc: Drill record, including date and participants	YES	PARTIAL	NO
3	**Were lessons from the drill documented and used to update the plan?** *A drill that doesn't feed back into plan improvement misses much of its value.* Doc: Post-drill review and plan revision record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Plan and drill record review*	Reviews the disaster response plan document and checks for evidence of an actual, dated drill.
ASK *Staff role-awareness interview*	Asks a staff member their specific role in the disaster plan, testing genuine familiarity versus general awareness a plan exists.
DOCUMENT *Post-drill improvement check*	Checks whether any post-drill review led to documented changes in the plan.

REFERENCES

Disaster preparedness frameworks consistently identify drill practice, not plan documentation alone, as the determining factor in real-world response effectiveness during mass casualty events.

Standard 5.3 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE
ASF-STD5-v3.0

WHY THIS STANDARD EXISTS

A disaster plan that has never been rehearsed reveals its gaps for the first time during an actual disaster, when there's no opportunity to learn from the failure safely. A practised plan surfaces its weaknesses in advance, when correcting them still costs nothing but time.

The evidence: Disaster preparedness frameworks consistently identify drill practice, not plan documentation alone, as the determining factor in real-world response effectiveness during mass casualty events.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, detailed disaster response plan exists and has been practised through a real drill.	✗ A plan exists only as a document, never practised through any drill.
✓ Staff can describe their specific role in the plan confidently.	✗ Staff asked about their role in a disaster scenario have no clear answer.
✓ Drill outcomes are documented and have led to real plan improvements.	✗ No evidence exists that drill lessons, if any drill occurred, changed the plan at all.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A drill was run once, years ago, with no repeat since.**
Staff turnover and plan changes mean a single historical drill doesn't reflect current readiness.

2 **The plan is detailed for the facility's own response but doesn't address coordination with external emergency services.**
Real disasters typically require coordination this kind of plan sometimes overlooks.

3 **A drill happened but was announced well in advance, testing preparation rather than genuine readiness.**
An announced drill tests whether staff can execute a rehearsed response, not whether they're actually ready for the unexpected.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review the current disaster plan for specificity and last drill date.

Week 2 Schedule and run a drill if none has occurred recently.

Week 3 Conduct a structured post-drill review and document specific plan improvements.

Ongoing Repeat drills on a fixed schedule, varying scenarios and announcement timing.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the drill date and participant list, not a general assurance drills happen.
Specific, dated evidence is the only real proof of practice.

Ask a random staff member their specific role, not a senior manager who wrote the plan.
Genuine, distributed familiarity is the real test, not authorship-level knowledge.

E-LEARNING academy.gmj.ge/std5-3-disaster-plan — 30 min · complete before self-assessment

Standard 5.4 **NON-NEGOTIABLE** · *Standard 5: Safety & Emergency Preparedness*

Fire Safety Is Real, Not Theoretical

ASSESSMENT *ASF-STD5-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

5.4
NON-NEGOTIABLE
L1

THE STANDARD

Fire Safety Is Real, Not Theoretical

Fire safety equipment is tested on schedule and an evacuation drill has actually been run, with real participation, not merely documented as a policy requirement.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is fire safety equipment tested on a defined schedule, with records kept?** *Extinguishers, alarms, and sprinkler systems specifically, not a general assumption of functionality.* Doc: Fire equipment testing log	YES	PARTIAL	NO
2	**Has an evacuation drill actually been run, with real staff and patient-area participation?** *A tabletop discussion of the evacuation plan is not the same as a physical drill.* Doc: Drill record, date and scope	YES	PARTIAL	NO
3	**Are evacuation routes kept genuinely clear, not obstructed in practice?** *A route that's clear on paper but blocked by stored equipment fails when it matters.* Doc: Route clearance check	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Equipment testing record review*	Reviews fire safety equipment testing records for schedule consistency.
DOCUMENT *Drill record check*	Checks for a specific, dated evacuation drill record, including scope and participation.
OBSERVE *Evacuation route check*	Physically checks that marked evacuation routes are genuinely clear and unobstructed.

REFERENCES

Fire safety and evacuation drill practice are established requirements in healthcare facility safety frameworks precisely because untested procedures reliably fail to translate into effective real-world response.

Standard 5.4 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE
ASF-STD5-v3.0

WHY THIS STANDARD EXISTS

Fire safety equipment that's present but untested, and evacuation procedures that exist only on paper, provide the appearance of safety without its substance. A real drill is what reveals whether people actually know what to do, not just whether a plan describes what they should do.

The evidence: Fire safety and evacuation drill practice are established requirements in healthcare facility safety frameworks precisely because untested procedures reliably fail to translate into effective real-world response.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Fire safety equipment is tested on a consistent, documented schedule.	✗ Equipment testing records show gaps or don't exist.
✓ A real evacuation drill has been run, with genuine staff and area participation.	✗ No evidence of an actual physical evacuation drill, only a written plan.
✓ Evacuation routes are verified clear at the time of assessment.	✗ Evacuation routes are found obstructed by stored equipment or furniture.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Equipment testing happens for alarms but less consistently for extinguishers or sprinkler systems.**
Different systems can develop different, uneven testing discipline over time.

2 **A drill was run in one part of the facility but not extended to all areas.**
Partial drilling tests partial readiness, leaving genuine gaps in areas never included.

3 **Evacuation routes are clear during the day but accumulate obstruction over time between checks.**
A route clear at drill time doesn't guarantee it stays clear as daily operations continue.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit fire safety equipment testing records for consistency across all system types.

Week 2 Schedule and run a genuine evacuation drill if none has occurred recently, covering all areas.

Week 3 Establish a routine evacuation route clearance check, not just a one-time verification.

Ongoing Repeat drills on a fixed schedule and monitor route clearance routinely.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the drill date and which areas were included, not a general statement drills occur.
Partial drilling is a common, specific gap worth checking directly.

Walk the evacuation routes yourself.
Obstruction accumulates gradually and may not be visible from records alone.

E-LEARNING academy.gmj.ge/std5-4-fire-safety — 30 min · complete before self-assessment

	Standard 5.5 NON-NEGOTIABLE · *Standard 5: Safety & Emergency Preparedness* **Workplace Violence Is Prevented, Not Just Responded To**	ASSESSMENT *ASF-STD5-v3.0*
CR FULL	TR FULL	SM FULL / ST FULL

5.5
NON-NEGOTIABLE
L1

THE STANDARD

Workplace Violence Is Prevented, Not Just Responded To

A specific workplace violence prevention policy covers violence from patients, visitors, and staff-on-staff, with real preventive measures in place — not a policy that only describes what happens after an incident occurs.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a written workplace violence policy covering violence from patients and visitors, and separately, staff-on-staff violence?** *Both categories explicitly, not just one assumed to cover the other.* Doc: Workplace violence policy document	YES	PARTIAL	NO
2	**Was the policy developed in consultation with staff, not written and issued without their input?** *Genuine consultation, since staff experience is what makes a prevention policy actually relevant.* Doc: Consultation record	YES	PARTIAL	NO
3	**Are real preventive measures in place — not only a response plan for after an incident occurs?** *Prevention, not just reaction — physical measures, staffing considerations, early warning signs training.* Doc: Preventive measures documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Policy scope review*	Reviews the workplace violence policy for coverage of both patient/visitor and staff-on-staff violence.
DOCUMENT *Consultation record check*	Checks for evidence the policy was developed with genuine staff consultation.
OBSERVE *Preventive measures check*	Checks for real, implemented preventive measures, not only a documented post-incident response plan.

REFERENCES

[3] *Established hospital accreditation frameworks, recognized in various forms across many countries, define workplace violence prevention as a required organizational practice, including violence from patients, visitors, and co-workers, requiring a written policy developed in consultation with staff.*

Standard 5.5 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE
ASF-STD5-v3.0

WHY THIS STANDARD EXISTS

Healthcare settings carry a disproportionately high risk of workplace violence, and a facility that only has a response plan for after an incident has already failed the more important task: reducing the likelihood of the incident happening at all through genuine prevention.

The evidence [3]: Established hospital accreditation frameworks, recognized in various forms across many countries, define workplace violence prevention as a required organizational practice, including violence from patients, visitors, and co-workers, requiring a written policy developed in consultation with staff.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A written policy explicitly covers both patient/visitor violence and staff-on-staff violence.	✗ The policy addresses only patient/visitor violence, silent on staff-on-staff incidents, or vice versa.
✓ The policy was developed with genuine staff consultation.	✗ The policy was issued without any staff consultation.
✓ Real preventive measures are visibly in place, not only a response plan.	✗ Only a post-incident response plan exists, with no genuine preventive measures.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **The policy covers patient and visitor violence well but staff-on-staff violence is addressed only vaguely.**
Workplace violence prevention often develops with more attention to external threats than internal ones.

2 **Consultation happened once at the policy's creation but hasn't been revisited as conditions changed.**
A policy set once without periodic review may not reflect current real risks or staff experience.

3 **Preventive measures exist for physical security but not for early recognition and de-escalation training.**
Physical measures alone don't address the interpersonal skills that often prevent escalation in the first place.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review the current policy for coverage of both violence categories and evidence of staff consultation.

Week 2 Consult staff directly if the policy was not originally developed with their input.

Week 3 Establish specific preventive measures, including de-escalation training, not only physical security or response planning.

Ongoing Revisit the policy and preventive measures periodically as conditions and staff feedback evolve.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff directly whether they were consulted on the policy.
Staff-reported consultation experience is more reliable than a policy document's stated process.

Ask about staff-on-staff violence specifically, not just patient and visitor incidents.
This category is more commonly under-addressed in practice.

E-LEARNING academy.gmj.ge/std5-5-workplace-violence — 30 min · complete before self-assessment

Standard 5.6 **NON-NEGOTIABLE** · *Standard 5: Safety & Emergency Preparedness*

Internal Emergency Alerts Are Clear, Consistent, and Trained

ASSESSMENT *ASF-STD5-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

5.6
NON-NEGOTIABLE
L1

THE STANDARD

Internal Emergency Alerts Are Clear, Consistent, and Trained

The facility has a clearly defined, documented internal emergency alert system — whether colour-coded or plain-language — covering the significant emergency types relevant to this facility, with every staff member trained and able to respond correctly, not assuming staff will infer meaning from context.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the facility have a clearly documented internal emergency alert system, whether colour-coded or plain-language?** *A specific, written system — not an assumption that staff will understand codes from general experience elsewhere.* Doc: Internal emergency alert system document	YES	PARTIAL	NO
2	**Are all staff, including new hires and temporary or agency staff, trained on this specific facility's system?** *Facility-specific training, not reliance on what a code meant at a previous workplace.* Doc: Training record covering all staff categories	YES	PARTIAL	NO
3	**Can staff correctly state what happens for each alert type used at this facility, not just recognise that an alert occurred?** *Understanding the required response, not just recognising that something is happening.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Alert system documentation review*	Reviews the facility's documented internal emergency alert system for clarity and completeness across relevant emergency types.
ASK *Staff response interview*	Asks staff, including newer or temporary staff, what a specific alert means and what their required response is.
DOCUMENT *Training coverage check*	Reviews training records to confirm coverage extends to temporary, agency, and newly hired staff, not only long-term permanent staff.

REFERENCES

[5] *Multiple national safety bodies now recommend plain-language emergency alerts specifically because colour-code meanings have been shown to vary significantly and dangerously between hospitals, regions, and countries.*

Standard 5.6 · *Standard 5: Safety & Emergency Preparedness*

Guidance & Learning

GUIDANCE
ASF-STD5-v3.0

WHY THIS STANDARD EXISTS

Hospital emergency codes are not internationally standardised — the same colour can mean entirely different things at different facilities, and this inconsistency has caused real, documented confusion, particularly for staff who move between institutions. What matters is not which specific system a facility chooses, but that its own system is clearly defined, consistently used, and genuinely understood by every relevant staff member.

The evidence [5]: Multiple national safety bodies now recommend plain-language emergency alerts specifically because colour-code meanings have been shown to vary significantly and dangerously between hospitals, regions, and countries.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A clear, documented internal alert system exists, whether colour-coded or plain-language.	✗ No documented system exists; staff are expected to infer meaning from context or prior experience elsewhere.
✓ All staff categories, including temporary and agency staff, are trained on this specific system.	✗ Training reaches long-term staff but not temporary, agency, or newly hired staff.
✓ Staff can correctly state the required response for each alert type used.	✗ Staff recognise that an alert occurred but cannot state the correct required response.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **The system is well understood by clinical staff but not by support, administrative, or facilities staff who may also need to respond.**
Emergency response often depends on more than just clinical staff, and gaps in non-clinical understanding create real coordination risk.

2 **Training happens at induction but is never refreshed, and understanding fades over time.**
A one-time training without periodic reinforcement doesn't guarantee lasting recall under real pressure.

3 **The system is clear for common alerts like cardiac arrest but less clear for less frequent ones like an infant abduction or bomb threat.**
Rarely used alerts are exactly the ones most likely to be forgotten without periodic reinforcement.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Document the facility's current internal emergency alert system clearly, whether colour-coded or plain-language.

Week 2 Extend training to cover all staff categories, including temporary and agency staff specifically.

Week 3 Consider whether a plain-language approach would reduce confusion, particularly for facilities with high staff turnover or many temporary staff.

Ongoing Refresh training periodically, with particular attention to less frequently used alert types.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a temporary or newer staff member specifically, not a long-term employee.
This is where genuine gaps in facility-specific understanding are most likely to surface.

Ask about a less common alert type, not just the most familiar one.
Understanding of rare but critical alerts often lags behind common ones like a cardiac arrest code.

E-LEARNING academy.gmj.ge/std5-6-internal-emergency-alerts — 30 min · complete before self-assessment

STANDARD 6

Aftercare & Follow-up

MANDATORY

3 criteria

Standard 6.1 **NON-NEGOTIABLE** · *Standard 6: Aftercare & Follow-up*

Every Discharged Patient Gets a Real Aftercare Plan

ASSESSMENT *ASF-STD6-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.1
NON-NEGOTIABLE
L1

THE STANDARD

Every Discharged Patient Gets a Real Aftercare Plan

Every discharged patient receives a documented aftercare plan they can explain back in their own words — not a printed sheet handed over on the way out the door.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every discharged patient receive a documented aftercare plan specific to their situation?** *Not a generic discharge sheet — content specific to this patient's condition and treatment.* Doc: Discharge plan sample	YES	PARTIAL	NO
2	**Can a recently discharged patient explain their own aftercare plan in their own words?** *Tests whether the plan was actually understood, not just handed over.* Doc: N/A — tested directly, e.g. follow-up call	YES	PARTIAL	NO
3	**Does the plan cover medication, warning signs, and who to contact if something goes wrong?** *A plan missing any of these three leaves a genuine gap in what the patient needs to manage safely at home.* Doc: Plan content checklist	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Discharge plan content review*	Reviews a sample of discharge plans for patient-specific content covering medication, warning signs, and contact information.
ASK *Patient understanding check*	Contacts or interviews a recently discharged patient to check whether they can describe their own aftercare plan accurately.
OBSERVE *Discharge process observation*	Observes how discharge instructions are actually delivered — rushed handover versus a genuine explanation.

REFERENCES

Discharge communication quality is consistently identified in patient safety literature as a determinant of post-discharge complications and readmission, distinct from the clinical quality of care received during admission.

Standard 6.1 · *Standard 6: Aftercare & Follow-up*

Guidance & Learning

GUIDANCE
ASF-STD6-v3.0

WHY THIS STANDARD EXISTS

Discharge is the moment responsibility for a patient's care transfers from the hospital to the patient themselves, often at exactly the point they're most fatigued, medicated, or overwhelmed to absorb complex instructions. A plan that isn't actually understood provides none of its intended protection, however thorough it looks on paper.

The evidence: Discharge communication quality is consistently identified in patient safety literature as a determinant of post-discharge complications and readmission, distinct from the clinical quality of care received during admission.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every patient receives a documented, patient-specific aftercare plan.	✗ Discharge information is a generic printed sheet, identical regardless of the patient's actual situation.
✓ Patients contacted after discharge can accurately describe their own plan.	✗ Patients contacted after discharge cannot describe what they were told.
✓ Plans consistently cover medication, warning signs, and who to contact for concerns.	✗ Plans are missing key elements like warning signs or contact information for concerns.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Plans are individualised for complex cases but generic for routine discharges.**
Perceived complexity often determines effort, even though routine-seeming discharges still carry real risk.

2 **The plan is thorough but delivered in the last rushed minutes before the patient leaves.**
Content quality doesn't matter if the delivery moment doesn't allow genuine understanding.

3 **Plans are given to the patient but not to an accompanying family member or caregiver, when relevant.**
A patient who is unwell or medicated may rely heavily on whoever is caring for them at home.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review a sample of recent discharge plans for genuine patient-specific content.

Week 2 Build discharge plan delivery into the schedule with real time allocated, not squeezed into a rushed final moment.

Week 3 Train discharging staff to check patient understanding directly before the patient leaves.

Ongoing Spot-check patient understanding through follow-up contact after discharge.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Contact a discharged patient directly if possible, rather than relying on the plan document alone.
The document proves content existed; the patient's recall proves it was actually understood.

Observe an actual discharge if the timing allows.
Rushed, last-minute delivery is a common, specific failure pattern worth seeing directly.

E-LEARNING academy.gmj.ge/std6-1-aftercare-plan — 30 min · complete before self-assessment

Standard 6.2 **NON-NEGOTIABLE** · *Standard 6: Aftercare & Follow-up*

A Real Mechanism Checks on the Patient After They Leave

ASSESSMENT *ASF-STD6-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.2
NON-NEGOTIABLE
L1

THE STANDARD

A Real Mechanism Checks on the Patient After They Leave

A genuine, defined mechanism exists to check on the patient after discharge — a scheduled call, a follow-up appointment, or an equivalent real contact — not merely "available on request" if the patient happens to reach back out.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is there a defined mechanism to actively check on patients after discharge, not just availability on request?** *The facility initiating contact, not merely being reachable if the patient calls first.* Doc: Follow-up protocol document	YES	PARTIAL	NO
2	**Does the mechanism apply consistently, not only for cases staff happen to remember?** *A follow-up system that depends on individual staff memory is not a reliable system.* Doc: Follow-up completion log	YES	PARTIAL	NO
3	**Is there a defined escalation if a follow-up contact reveals a concerning symptom or complication?** *Detecting a problem during follow-up is only useful if something happens as a result.* Doc: Escalation protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Follow-up protocol and log review*	Reviews the defined follow-up mechanism and checks completion records against actual recent discharges.
OBSERVE *Follow-up contact sample check*	Checks whether a sample of recently discharged patients actually received the defined follow-up contact.
ASK *Escalation protocol interview*	Asks staff what happens if a follow-up contact reveals a concerning symptom.

REFERENCES

Structured post-discharge follow-up contact is associated with earlier identification of complications and reduced avoidable readmission in health services literature, distinct from the quality of the discharge plan itself.

Standard 6.2 · *Standard 6: Aftercare & Follow-up*
Guidance & Learning

GUIDANCE
ASF-STD6-v3.0

WHY THIS STANDARD EXISTS

Placing the entire burden of follow-up on a patient who has just been discharged, often unwell and unfamiliar with warning signs, means the people most at risk of a missed complication are also the ones least likely to reliably initiate contact. A system that reaches out, rather than waiting to be reached, closes that gap.

The evidence: Structured post-discharge follow-up contact is associated with earlier identification of complications and reduced avoidable readmission in health services literature, distinct from the quality of the discharge plan itself.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A defined, proactive follow-up mechanism is applied consistently to every discharge.	✗ Follow-up happens only if the patient calls back with a problem.
✓ Follow-up completion is tracked and verifiable, not dependent on individual memory.	✗ No tracking exists to confirm follow-up actually happened for a given patient.
✓ A clear escalation path exists and is used when follow-up reveals a concern.	✗ Staff are uncertain what to do if a follow-up call reveals a concerning symptom.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Follow-up happens reliably for high-risk discharges but inconsistently for routine ones.**
Perceived risk level often determines effort, though routine discharges still carry genuine risk of missed complications.

2 **A follow-up call is made but doesn't ask specific enough questions to catch a real problem.**
A generic "how are you feeling" check may miss a specific warning sign a targeted question would catch.

3 **Follow-up is attempted but not completed if the patient doesn't answer the first call.**
A single missed attempt without a retry protocol can leave the highest-risk, hardest-to-reach patients uncovered.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent discharges for evidence of actual follow-up contact, not just a policy that one should occur.

Week 2 Define a specific follow-up mechanism, timing, and content — what questions get asked.

Week 3 Build a simple tracking log so follow-up completion is verifiable, not assumed.

Ongoing Review the escalation protocol periodically, particularly for cases where a real concern was caught.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a completion log, not a description of the intended process.
A tracked, verifiable record is the only real evidence the mechanism functions consistently.

Ask about retry attempts for patients who don't answer the first follow-up call.
The hardest-to-reach patients are sometimes also the highest-risk ones.

E-LEARNING academy.gmj.ge/std6-2-followup-mechanism — 30 min · complete before self-assessment

Standard 6.3 **NON-NEGOTIABLE** · *Standard 6: Aftercare & Follow-up*

Patients Can Complain After Leaving, and Complaints Are Actually Read

ASSESSMENT *ASF-STD6-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.3
NON-NEGOTIABLE
L1

THE STANDARD

Patients Can Complain After Leaving, and Complaints Are Actually Read

A complaint or feedback channel exists that a patient can use after they've left the facility, with evidence that complaints are genuinely read and acted on, not merely collected.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Can a patient submit a complaint or feedback after leaving the facility, not only while present?** *A suggestion box in the waiting room alone doesn't meet this — there needs to be a way to reach the facility afterward too.* Doc: Complaint channel description, e.g. phone/email/form	YES	PARTIAL	NO
2	**Is there evidence complaints are actually read and result in a response, not just filed?** *A collected complaint with no follow-through provides no real value to the patient or the facility.* Doc: Complaint response record sample	YES	PARTIAL	NO
3	**Have any complaints led to a documented change in practice?** *A complaint system that has never once led to a change is worth questioning, not just checking for the existence of a form.*	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Post-discharge channel accessibility check*	Verifies a real, accessible way exists for a discharged patient to submit a complaint or feedback.
DOCUMENT *Response record review*	Reviews a sample of submitted complaints for evidence of an actual response, not just receipt.
DOCUMENT *Practice-change history check*	Checks for any documented instance where a complaint led to a specific change in facility practice.

REFERENCES

Patient complaint systems with demonstrated action on findings are identified in patient safety literature as a distinct quality signal from complaint volume alone — the presence of a channel says little without evidence it functions.

Standard 6.3 · *Standard 6: Aftercare & Follow-up*

Guidance & Learning

GUIDANCE
ASF-STD6-v3.0

WHY THIS STANDARD EXISTS

A complaint channel only available while the patient is physically present misses exactly the concerns that surface once someone has had time to reflect on their experience, or once a delayed complication reveals a problem with the care they received. And a channel that collects complaints without demonstrable follow-through teaches patients their feedback doesn't matter, discouraging exactly the reporting that helps a facility improve.

The evidence: Patient complaint systems with demonstrated action on findings are identified in patient safety literature as a distinct quality signal from complaint volume alone — the presence of a channel says little without evidence it functions.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A clear, accessible complaint channel exists for patients after they've left.	✗ No channel exists beyond an in-person suggestion box, unusable after discharge.
✓ Sampled complaints show genuine responses, not just acknowledgment of receipt.	✗ Complaints are collected but show no evidence of response.
✓ At least one documented instance exists of a complaint leading to a real practice change.	✗ Nobody can recall a complaint ever leading to any change in practice.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **A channel exists but isn't clearly communicated to patients before they leave.**
Availability that patients don't know about functions similarly to no availability at all.

2 **Complaints receive an acknowledgment but not a substantive response addressing the actual concern.**
A form-letter acknowledgment can satisfy the letter of "responding" while providing no real value.

3 **Serious complaints are reviewed and acted on; minor ones accumulate without individual response.**
Triage by severity is reasonable, but complaints below a certain threshold shouldn't disappear entirely.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current complaint channel accessibility, particularly for discharged patients.

Week 2 Ensure the channel is clearly communicated as part of the discharge process.

Week 3 Establish a defined response process and timeframe for submitted complaints.

Ongoing Track and periodically review whether complaints are leading to real practice changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how a discharged patient would actually find and use the complaint channel.
Theoretical availability and genuine patient-facing accessibility aren't always the same.

Ask for a specific example of a complaint that changed something.
A real example, or its honest absence, reveals more than a description of the general process.

E-LEARNING academy.gmj.ge/std6-3-complaints — 30 min · complete before self-assessment

STANDARD 7

Governance & Management

MANDATORY

13 criteria

Standard 7.1 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

The Board Is Real and Accountable

ASSESSMENT *ASF-STD7-v3.0*

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

7.1
NON-NEGOTIABLE
L1

THE STANDARD

The Board Is Real and Accountable

A governing body exists, with named members and clear, documented authority over safety and quality — not an informal ownership arrangement functioning without real oversight structure.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a documented governing body with named members and defined terms of office?** *A charter or bylaws naming members and terms, not an informal ownership arrangement.* Doc: Governance charter or bylaws	YES	PARTIAL	NO
2	**Does the governing body meet on a fixed schedule with minutes retained?** *Minutes showing attendance, decisions, and follow-up actions, not just that a meeting occurred.* Doc: Meeting minutes, last four	YES	PARTIAL	NO
3	**Does the board formally review quality and safety performance at each meeting, not only financial performance?** *A standing quality agenda item with real data discussed, not an afterthought.* Doc: Quality report presented to governing body	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Charter and minutes review*	Reviews the governance charter and recent minutes for quorum, attendance, and whether quality data led to tracked follow-up.
ASK *Board member interview*	Asks a governing body member, without the CEO present, to describe the last quality or safety issue the board acted on.
OBSERVE *Reporting line check*	Traces whether incident reports and quality indicators actually reach board level, or stop at management.

REFERENCES

[12] *Jha AK, Epstein AM. Hospital governance and the quality of care. Health Aff (Millwood). 2010;29(1):182-187 — hospitals whose boards spent more time on quality performed significantly better on process-of-care measures.*

Standard 7.1 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

Without a functioning governing body, there is no accountability mechanism above clinical leadership for safety and quality. A board that exists on paper but has no real named members or documented authority provides the appearance of oversight without its substance.

The evidence [12]: Jha AK, Epstein AM. Hospital governance and the quality of care. Health Aff (Millwood). 2010;29(1):182-187 — hospitals whose boards spent more time on quality performed significantly better on process-of-care measures.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Governance charter names members, terms, and quorum rules in writing.	✗ Governing body exists on paper only; no minutes can be produced.
✓ Quality and safety data is reviewed at every meeting, not only annually.	✗ Meetings occur but only discuss budget and construction, never outcomes.
✓ Minutes show specific follow-up actions with named owners and deadlines.	✗ Quality incidents are known to management for months before the board hears of them.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 The board meets regularly but the quality agenda item is a formality with no real discussion.
Presence on the agenda doesn't guarantee genuine engagement with the content.

2 Minutes exist but record attendance only, not actual decisions taken.
A record of who was present says nothing about what was actually decided.

3 One board member drives all quality engagement, with others largely passive.
Genuine collective oversight requires more than one engaged individual carrying the whole function.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent board minutes for genuine quality discussion versus formality.

Week 2 Add or reinforce a standing quality and safety agenda item with real data presented.

Week 3 Identify the reporting pathway gap between incident/quality data and board-level visibility, if one exists.

Ongoing Track board-level follow-up actions to closure, not just to being raised.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the last four sets of minutes, not the charter alone.
A polished charter proves nothing about actual practice.

Interview a board member alone, not with the CEO present.
If a board member cannot answer without looking to the CEO, oversight is not independent in practice, whatever the bylaws say.

E-LEARNING academy.gmj.ge/std7-1-governance — 30 min · complete before self-assessment

Standard 7.2 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

There Is a Written Strategic Plan

ASSESSMENT *ASF-STD7-v3.0*

CR N/A	TR FULL	SM FULL	ST FULL

7.2
NON-NEGOTIABLE
L1

THE STANDARD

There Is a Written Strategic Plan

A documented plan states the hospital's mission and genuinely guides resourcing decisions — not a one-page mission poster disconnected from how money and staff time actually get allocated.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a written strategic plan covering at least a multi-year horizon?** *Not an annual budget alone — a plan with genuine forward horizon.* Doc: Strategic plan document	YES	PARTIAL	NO
2	**Does the plan include a clear mission statement describing who the hospital serves and how?** *Specific enough to guide real decisions, not generic enough to apply to any hospital anywhere.* Doc: Mission statement text	YES	PARTIAL	NO
3	**Can a resourcing decision from the last year be traced back to something in the plan?** *Tests whether the plan actually influences decisions, not just whether it exists.* Doc: Example resourcing decision with plan linkage	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Plan and minutes cross-check*	Reviews the strategic plan against governing body minutes to check for genuine linkage to real decisions.
ASK *Front-line staff interview*	Asks staff from different departments to state the hospital's mission in their own words.
OBSERVE *Wall and induction material check*	Checks whether the mission is genuinely integrated into staff-facing materials, not only leadership documents.

REFERENCES

[11] *Institute for Healthcare Improvement. Framework for effective board governance of health system quality. Boston: IHI; 2018 — identifies strategic alignment between stated mission and resource allocation as a determinant of sustained quality improvement.*

Standard 7.2 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

A strategic plan that doesn't influence real resourcing decisions is a wall decoration, not a plan. The test isn't whether a plan exists but whether decisions about money, staffing, and priorities can be traced back to it.

The evidence [11]: Institute for Healthcare Improvement. Framework for effective board governance of health system quality. Boston: IHI; 2018 — identifies strategic alignment between stated mission and resource allocation as a determinant of sustained quality improvement.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The plan names the population served, concrete goals, and a resourcing rationale.	✗ The plan is a one-page mission poster with no operational content.
✓ Front-line staff across departments describe a consistent, recognisable mission.	✗ Staff across departments give inconsistent or vague descriptions of the hospital's mission.
✓ At least one recent resourcing decision is clearly traceable to a stated strategic priority.	✗ No resourcing decision can be linked back to anything in the written plan.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 A plan exists and is well written but was never actually communicated to front-line staff.
Quality of the document doesn't matter if it never reaches the people expected to align with it.

2 The plan states priorities but the annual budget process runs independently of it.
Two parallel processes that don't reference each other produce a plan with no real teeth.

3 Leadership can trace decisions to the plan; front-line staff cannot see the connection.
Strategic alignment that exists only at the top doesn't reach the level where most decisions actually get executed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review the current plan for specificity and whether recent resourcing decisions reference it.

Week 2 Communicate the plan's core priorities directly to front-line staff, not just leadership.

Week 3 Link the next resourcing or budget decision explicitly and visibly to a stated strategic priority.

Ongoing Revisit the plan on a fixed schedule, not only when it happens to come up.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff in different departments the same question separately.
Consistency across independent answers reveals genuine organisational alignment.

Ask for one specific recent decision and trace its rationale.
A real, traceable example is worth more than a general assurance the plan guides decisions.

E-LEARNING academy.gmj.ge/std7-2-strategic-plan — 30 min · complete before self-assessment

Standard 7.3 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Policy Actually Gets Followed

ASSESSMENT *ASF-STD7-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

7.3
NON-NEGOTIABLE
L1

THE STANDARD

Policy Actually Gets Followed

A policy framework exists and staff can describe how it's genuinely applied in practice, not merely confirm that policies are filed and technically available.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Can staff describe how a specific, named policy is actually applied in their daily work?** *Not whether they know a policy exists — whether they can describe applying it.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is there a mechanism to check policy adherence, not just policy existence?** *A policy audit or spot-check process, distinct from simply confirming documents are filed.* Doc: Policy adherence audit record	YES	PARTIAL	NO
3	**When a policy-practice gap is found, is there a defined response, not just noting the discrepancy?** *Identifying a gap without addressing it provides limited real value.* Doc: Gap resolution record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Staff application interview*	Asks a staff member to describe how they actually apply a specific named policy in their work, not to recite its existence.
DOCUMENT *Adherence audit review*	Checks for evidence of any process verifying policy adherence, beyond confirming documents are filed.
OBSERVE *Practice-policy comparison*	Directly observes a practice area and compares actual behaviour against the stated policy for that area.

REFERENCES

Policy-practice gaps are consistently identified in healthcare quality literature as a distinct failure mode from policy absence — the existence of a written policy is not evidence of its implementation.

Standard 7.3 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

A policy nobody follows provides the appearance of governance without its function. The real question isn't whether a policy document exists — it's whether staff behaviour actually reflects it, which is a fundamentally different, harder thing to verify.

The evidence: Policy-practice gaps are consistently identified in healthcare quality literature as a distinct failure mode from policy absence — the existence of a written policy is not evidence of its implementation.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff describe specific, genuine application of policy in their actual work.	✗ Staff can confirm policies exist but cannot describe how they actually apply to daily work.
✓ A real adherence-checking mechanism exists, distinct from document filing.	✗ No mechanism exists to verify adherence beyond confirming documents are filed.
✓ Identified gaps between policy and practice trigger a defined, followed response.	✗ Known gaps between policy and practice persist without any response.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Policies are followed for well-established practices but not consistently for newer ones.**
Established habit reinforces old policy adherence; new policies need active reinforcement to take hold.

2 **An adherence check exists but only samples a small, easily-prepared subset of practice.**
A narrow or predictable audit scope can miss where real gaps live.

3 **Gaps are identified during audits but corrective action isn't consistently tracked to completion.**
Identification without follow-through leaves the underlying gap unresolved.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Select several key policies and ask a sample of staff to describe their actual application.

Week 2 Establish or reinforce a genuine adherence-checking mechanism, not just document review.

Week 3 Build a tracked resolution process for any policy-practice gap identified.

Ongoing Rotate which policies get checked, avoiding a predictable, easily-prepared audit pattern.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask about application, not existence.
"Do you know this policy exists" and "how do you actually apply it" surface very different answers.

Pick a policy area to observe directly, not just review on paper.
Direct observation reveals gaps document review alone cannot.

E-LEARNING academy.gmj.ge/std7-3-policy-adherence — 30 min · complete before self-assessment

Standard 7.4 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Patient Information Stays Private

ASSESSMENT *ASF-STD7-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

7.4
NON-NEGOTIABLE
L1

THE STANDARD

Patient Information Stays Private

Confidentiality is protected physically and culturally throughout the facility, not only referenced in a written policy that doesn't translate into actual practice.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Are screens and monitors positioned so patient information isn't visible to passersby or other patients?** *Physical positioning, checked directly, not assumed from a policy statement.* Doc: Photo audit of screen positioning	YES	PARTIAL	NO
2	**Are clinical conversations conducted where they can't be overheard by other patients or visitors?** *Curtains, closed doors, or private spaces genuinely used, not just available.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Do staff understand and apply confidentiality practices consistently, not only when reminded?** *Tests whether privacy protection is habitual, not situational.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Physical privacy check*	Walks through patient-facing areas checking screen positioning, conversation privacy, and general physical confidentiality protection.
OBSERVE *Conversation audibility check*	Checks whether clinical conversations happening in the facility can be overheard from adjacent areas.
ASK *Staff practice interview*	Asks staff to describe specific ways they protect patient confidentiality in their daily work, beyond citing the policy.

REFERENCES

Patient confidentiality protection frameworks consistently identify physical environment design and staff behaviour, not policy documentation alone, as the practical determinants of actual privacy protection.

Standard 7.4 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

A confidentiality policy that exists on paper while screens face waiting areas and conversations happen within earshot of other patients provides no real protection. Privacy has to be built into the physical and behavioural fabric of the facility, not just stated as an intention.

The evidence: Patient confidentiality protection frameworks consistently identify physical environment design and staff behaviour, not policy documentation alone, as the practical determinants of actual privacy protection.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Screens and monitors are consistently positioned away from public view.	✗ Screens face waiting areas or corridors, visible to anyone passing.
✓ Clinical conversations happen in genuinely private spaces, doors or curtains actually used.	✗ Clinical conversations are regularly audible to other patients.
✓ Staff describe specific, habitual privacy practices without needing to reference a policy document.	✗ Staff can cite the confidentiality policy but describe no specific practical habits.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Physical privacy is good in some areas but overlooked in others, like corridors or shared bays.**
Privacy protection is often strongest where it was deliberately designed and weaker in less-considered spaces.

2 **Staff are conscientious about privacy when reminded but inconsistent otherwise.**
Habitual practice is a different, more reliable thing than practice prompted by reminder.

3 **Curtains or private spaces exist but aren't consistently used under time pressure.**
Infrastructure for privacy doesn't guarantee its use during a busy shift.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Audit screen positioning and conversation privacy across all patient-facing areas.

Week 2 Reposition screens and reinforce use of private spaces where gaps are found.

Week 3 Brief staff specifically on habitual, not just reminded, confidentiality practice.

Ongoing Spot-check physical privacy periodically, including in less-considered shared spaces.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Walk the space as a visitor would, checking what's actually visible or audible.
A staff member's familiar routine can make an obvious privacy gap invisible to them.

Ask staff for specific examples of their own privacy practices.
Specific, concrete habits reveal genuine internalisation better than reciting the policy.

E-LEARNING academy.gmj.ge/std7-4-confidentiality — 30 min · complete before self-assessment

Standard 7.5 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Medical Records Are Complete

ASSESSMENT *ASF-STD7-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.5
NON-NEGOTIABLE
L1

THE STANDARD

Medical Records Are Complete

Records contain all mandatory elements and are genuinely audited for completeness on a regular basis, not assumed complete because a template exists.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a defined list of mandatory record elements for each type of encounter?** *A specific, checkable list, not a general expectation of thoroughness.* Doc: Mandatory elements list	YES	PARTIAL	NO
2	**Are records regularly audited for completeness against that list?** *Genuine audit, not assumption of completeness because a template was used.* Doc: Completeness audit record	YES	PARTIAL	NO
3	**Are gaps found during audits actually addressed, not just noted?** *Identifying an incomplete record without correcting it leaves the underlying risk unresolved.* Doc: Gap resolution record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Mandatory elements definition check*	Reviews the defined list of mandatory record elements for specificity and completeness.
DOCUMENT *Completeness audit review*	Reviews recent completeness audit records and checks for genuine, regular practice.
DOCUMENT *Gap resolution check*	Checks whether gaps identified in past audits were actually resolved, not just documented as found.

REFERENCES

Medical record completeness auditing is a recognised quality assurance practice specifically because template existence alone does not guarantee consistent completion in real clinical practice.

Standard 7.5 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

An incomplete record is a specific, quiet risk — the information a future clinician needs might simply not be there, discovered only at the moment it's needed most. Regular auditing is what catches completeness gaps before they matter clinically, rather than after.

The evidence: Medical record completeness auditing is a recognised quality assurance practice specifically because template existence alone does not guarantee consistent completion in real clinical practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, defined list of mandatory elements exists for each encounter type.	✗ No specific mandatory elements list exists beyond general expectation.
✓ Regular, genuine completeness audits are conducted with documented findings.	✗ No audit process exists, or completeness is assumed rather than checked.
✓ Identified gaps are tracked to resolution, not left open.	✗ Gaps found in past audits remain unresolved with no tracking.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Audits happen but only sample a small, non-representative set of records.**
A narrow sample can miss where real completeness gaps concentrate.

2 **Completeness is checked for structural fields but not for genuine clinical content quality.**
A record can be structurally complete while still lacking substantively useful clinical detail.

3 **Gaps are found and noted but resolution isn't consistently tracked to closure.**
Identification without follow-through leaves the same underlying risk unaddressed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review the current mandatory elements list and recent audit practice, if any exists.

Week 2 Establish or reinforce a genuine, regular completeness audit process.

Week 3 Build a gap resolution tracker so identified issues are actually closed.

Ongoing Widen the audit sample periodically to avoid a narrow, predictable pattern.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for actual audit records, not a description of the intended process.
Dated findings are the only real evidence a genuine audit occurs.

Check whether a past identified gap was actually resolved.
Resolution tracking reveals whether the audit process has real teeth.

E-LEARNING academy.gmj.ge/std7-5-record-completeness — 30 min · complete before self-assessment

Standard 7.6 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Patient Data Is Kept Secure

ASSESSMENT *ASF-STD7-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.6
NON-NEGOTIABLE
L1

THE STANDARD

Patient Data Is Kept Secure

Health information is protected with defined access controls and a genuine breach response plan, using practical, achievable security measures appropriate to the facility's resources.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are access controls in place restricting patient data access to staff who need it for their role?** *Role-based restriction, not general access available to any staff member.* Doc: Access control policy and implementation	YES	PARTIAL	NO
2	**Is there a documented breach response plan, specific and actionable?** *Not a general statement of concern — a named process for what happens if a breach occurs.* Doc: Breach response plan document	YES	PARTIAL	NO
3	**Have access controls and the breach plan been reviewed or tested recently?** *An untested plan or unreviewed control list may not reflect current reality.* Doc: Review or test record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Access control review*	Reviews access control policy and checks implementation against actual staff access levels.
DOCUMENT *Breach response plan check*	Reviews the breach response plan for specificity and actionable steps, not general statements.
ASK *Staff awareness interview*	Asks staff whether they know the breach response process and their role in it, if applicable.

REFERENCES

Health information security frameworks consistently identify access control and incident response planning, rather than technology sophistication alone, as the primary determinants of practical data protection in resource-constrained settings.

Standard 7.6 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

Patient data security failures compound the harm of any breach with a loss of trust that can outlast the immediate incident. Access controls and a real, rehearsed breach response are what limit both the likelihood of a breach and the damage if one occurs, and neither requires expensive enterprise systems to be genuine.

The evidence: Health information security frameworks consistently identify access control and incident response planning, rather than technology sophistication alone, as the primary determinants of practical data protection in resource-constrained settings.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Access controls are genuinely role-based and reflect actual staff need.	✗ Data access is broadly available regardless of staff role.
✓ A specific, actionable breach response plan exists and has been reviewed recently.	✗ No breach response plan exists, or it exists only as a vague statement of concern.
✓ Relevant staff know their role in the breach response process.	✗ Staff are unaware any breach response process exists.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Access controls exist for electronic records but not consistently for physical files.**
Security attention often concentrates on digital systems while physical record access remains loosely controlled.

2 **A breach response plan exists but has never been reviewed since it was written.**
An unreviewed plan may not reflect current systems, staff, or actual risk.

3 **Access controls are correctly configured but not periodically re-reviewed as staff roles change.**
Role changes and departures can leave stale access permissions unless actively managed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current access controls against actual staff roles for any over-broad access.

Week 2 Draft or review the breach response plan for specificity and actionable steps.

Week 3 Brief relevant staff on their role in the breach response process.

Ongoing Review access control assignments periodically as staff roles change.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Check physical record access, not only electronic systems.
Security attention often skews toward digital systems while physical files remain loosely controlled.

Ask when the breach plan was last reviewed, not just whether it exists.
A plan's age relative to current systems and staff matters as much as its existence.

E-LEARNING academy.gmj.ge/std7-6-data-security — 30 min · complete before self-assessment

Standard 7.7 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Records Are Kept Exactly as Long as Required

ASSESSMENT *ASF-STD7-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.7
NON-NEGOTIABLE
L1

THE STANDARD

Records Are Kept Exactly as Long as Required

A retention policy governs how long records are kept and how they're disposed of, aligned with the specific legal requirement in this facility's jurisdiction, not a generic assumption.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does a written retention policy exist, specifying how long different record types are kept?** *Specific durations by record type, not a vague general statement.* Doc: Retention policy document	YES	PARTIAL	NO
2	**Is the retention period aligned with the actual legal requirement in this jurisdiction?** *Verified against the real legal requirement, not assumed or copied from another context.* Doc: Legal requirement reference	YES	PARTIAL	NO
3	**Is disposal of records past their retention period conducted securely and documented?** *Disposal that protects confidentiality even as the record is destroyed.* Doc: Disposal record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Retention policy review*	Reviews the retention policy for specificity by record type.
DOCUMENT *Legal alignment check*	Checks whether the stated retention periods align with the actual legal requirement in this jurisdiction.
DOCUMENT *Disposal record review*	Reviews records of secure disposal for any record past its retention period.

REFERENCES

Health record retention requirements vary by jurisdiction and are legally defined precisely because both premature destruction and indefinite retention carry distinct, documented risks.

Standard 7.7 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

Records kept too briefly can be destroyed before they're legally or clinically needed again; records kept indefinitely accumulate unnecessary risk and cost. A retention policy aligned to the actual legal requirement is what gets this balance right, rather than guessing.

The evidence: Health record retention requirements vary by jurisdiction and are legally defined precisely because both premature destruction and indefinite retention carry distinct, documented risks.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, written retention policy exists by record type.	✗ No specific retention policy exists beyond a general assumption.
✓ Retention periods are verified against actual legal requirements, not assumed.	✗ Stated retention periods don't match the actual legal requirement, or were never checked.
✓ Disposal is conducted securely with documented records.	✗ No evidence of secure, documented disposal exists.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 A policy exists but was written years ago and never checked against a legal requirement update.
Legal requirements can change, and a policy set once can quietly become outdated.

2 Retention periods are correct for most record types but a specific category was overlooked.
Comprehensive-looking policies can still miss a specific record type with different legal requirements.

3 Disposal happens but isn't consistently documented.
Undocumented disposal leaves no verifiable evidence the process actually occurred as required.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review the current retention policy against the actual legal requirement for this jurisdiction.

Week 2 Correct any misalignment found and update the policy accordingly.

Week 3 Establish a documented, secure disposal process for records past retention.

Ongoing Recheck legal requirement alignment periodically, as regulations can change.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the specific legal citation the retention period is based on.
A specific reference, or its absence, reveals whether this was genuinely checked or assumed.

Check disposal documentation, not just the retention policy itself.
A correct policy on paper doesn't guarantee correct, documented execution.

E-LEARNING academy.gmj.ge/std7-7-record-retention — 30 min · complete before self-assessment

Standard 7.8 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Incidents Are Actually Reported

ASSESSMENT *ASF-STD7-v3.0*

CR FULL	TR FULL	SM FULL	ST FULL

7.8
NON-NEGOTIABLE
L1

THE STANDARD

Incidents Are Actually Reported

An accessible incident reporting system exists and staff genuinely use it — measured by real reporting volume and pattern, not merely by the system's technical availability.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is the incident reporting system genuinely accessible to all staff, not just management?** *Accessible in practice, at the point of work, not buried in an administrative system.* Doc: Reporting system access description	YES	PARTIAL	NO
2	**Does actual reporting volume suggest genuine use, not just technical availability?** *A system that exists but receives almost no reports over time suggests a use problem, not a safety-perfect facility.* Doc: Reporting volume data over time	YES	PARTIAL	NO
3	**Do staff believe they can report without fear of punitive consequence?** *Genuine psychological safety, not just a stated non-punitive policy.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Reporting volume review*	Reviews incident reporting volume and pattern over time for evidence of genuine, ongoing use.
ASK *Psychological safety interview*	Asks front-line staff directly whether they feel safe reporting an incident, including one they caused themselves.
OBSERVE *System accessibility check*	Checks how genuinely accessible the reporting mechanism is at the actual point of work, not just in principle.

REFERENCES

Incident reporting culture, specifically the psychological safety staff feel around reporting without fear of punitive consequence, is consistently identified as the primary determinant of reporting volume, more so than system accessibility alone.

Standard 7.8 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

An incident reporting system nobody uses provides no safety value regardless of how well-designed it is. The barrier to reporting is almost always fear of blame, not the mechanics of the form — which means the real work is building psychological safety around reporting, not just building the system itself.

The evidence: Incident reporting culture, specifically the psychological safety staff feel around reporting without fear of punitive consequence, is consistently identified as the primary determinant of reporting volume, more so than system accessibility alone.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Reporting volume reflects genuine, ongoing use across staff levels, not just management.	✗ Reporting volume is minimal or has dropped sharply with no clear explanation.
✓ Staff describe genuine confidence they can report without punitive consequence.	✗ Staff describe fear of blame or consequence as a reason they hesitate to report.
✓ The reporting system is accessible directly at the point of work.	✗ The reporting system exists but is difficult to access in practice.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **Reporting happens for minor incidents but staff hesitate to report anything involving their own error.**
Psychological safety often varies by perceived personal exposure, not uniformly across incident types.

2 **Senior staff report reliably; junior staff report far less.**
Hierarchy can create very different real experiences of psychological safety within the same facility.

3 **A non-punitive policy exists on paper but staff describe a past incident where reporting led to real consequences.**
A single remembered punitive response can undermine trust in the policy for a long time afterward.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review reporting volume trends and identify any concerning drop or pattern.

Week 2 Interview a cross-section of staff, including junior staff, about their actual confidence in reporting.

Week 3 Address any specific past incident or perception undermining psychological safety directly and visibly.

Ongoing Track reporting volume as an ongoing indicator, investigating any significant drop.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask junior staff specifically, not only senior staff.
Hierarchy can create very different real experiences within the same facility.

Ask about reporting one's own error specifically, not just witnessing someone else's.
Self-reporting confidence is usually the harder, more revealing test of genuine psychological safety.

E-LEARNING academy.gmj.ge/std7-8-incident-reporting — 30 min · complete before self-assessment

Standard 7.9 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Serious Incidents Get Properly Investigated

ASSESSMENT *ASF-STD7-v3.0*

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.9
NON-NEGOTIABLE
L1

THE STANDARD

Serious Incidents Get Properly Investigated

Root cause analysis is genuinely used for serious incidents, with a resulting, tracked action plan — not a brief note explaining what happened without examining why it happened.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a structured root cause analysis method used for serious incidents, not just a brief incident note?** *A defined methodology examining systemic factors, not a one-paragraph summary.* Doc: RCA methodology and completed sample	YES	PARTIAL	NO
2	**Does the RCA result in a specific, tracked action plan?** *Findings without a resulting plan don't translate into prevention.* Doc: Action plan document	YES	PARTIAL	NO
3	**Are action plan items tracked to completion, not left open indefinitely?** *An action item that's never closed provides no real protection against recurrence.* Doc: Action plan completion tracking	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *RCA methodology and sample review*	Reviews the RCA methodology used and checks a sample of completed analyses for genuine systemic examination.
DOCUMENT *Action plan review*	Reviews whether RCAs result in specific, documented action plans, not just findings.
DOCUMENT *Completion tracking check*	Checks whether action plan items are tracked to actual completion.

REFERENCES

Root cause analysis methodology is a well-established patient safety practice specifically because surface-level incident review, without deeper systemic examination, is consistently associated with recurrence of preventable events.

Standard 7.9 · *Standard 7: Governance & Management*

Guidance & Learning

GUIDANCE
ASF-STD7-v3.0

WHY THIS STANDARD EXISTS

An incident review that identifies what happened without examining the underlying system conditions that allowed it will likely see the same incident recur. Root cause analysis exists specifically to find the systemic factors a surface-level review misses.

The evidence: Root cause analysis methodology is a well-established patient safety practice specifically because surface-level incident review, without deeper systemic examination, is consistently associated with recurrence of preventable events.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured RCA methodology is genuinely applied to serious incidents.	✗ Serious incidents receive only a brief note, no structured systemic analysis.
✓ RCAs consistently result in specific, documented action plans.	✗ RCAs identify findings but produce no specific action plan.
✓ Action items are tracked and demonstrably completed, not left open.	✗ Action items remain open indefinitely with no completion tracking.

MOST COMMON REASONS HOSPITALS SCORE PARTIAL

1 **RCA is conducted for the most severe incidents but not consistently applied to moderately serious ones.**
A narrower-than-intended threshold for triggering RCA can leave real systemic issues unexamined.

2 **Action plans are written but implementation isn't consistently tracked to actual completion.**
A good plan on paper doesn't guarantee the underlying system issue actually got fixed.

3 **RCA identifies contributing factors but stops short of genuinely systemic root causes.**
A surface-level analysis that names immediate causes without examining deeper conditions misses much of RCA's value.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent serious incidents for evidence of genuine RCA versus brief incident notes.

Week 2 Ensure RCA methodology is applied consistently against a clear, defined severity threshold.

Week 3 Build a tracked action plan process ensuring RCA findings translate into completed changes.

Ongoing Audit action plan completion rates periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a completed RCA example, not a description of the methodology.
A real example reveals whether the analysis goes genuinely systemic or stays surface-level.

Check whether action items from past RCAs were actually completed.
Completion tracking is where good analysis either translates into real prevention or doesn't.

E-LEARNING academy.gmj.ge/std7-9-root-cause-analysis — 30 min · complete before self-assessment

Standard 7.10 **NON-NEGOTIABLE** · *Standard 7: Governance & Management*

Safety Culture Is Actually Measured

ASSESSMENT *ASF-STD7-v3.0*

CR N/A	TR FULL	SM ADAPTED	ST FULL

7.10
NON-NEGOTIABLE
L1

THE STANDARD

Safety Culture Is Actually Measured

A validated survey measures whether staff genuinely feel safe raising concerns, conducted regularly and acted on, not assumed from the absence of complaints.

HOSPITAL SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a validated safety culture survey conducted, not an informal or ad hoc check?** *A recognised, validated tool, not an internally improvised questionnaire.* Doc: Survey tool and administration record	YES	PARTIAL	NO
2	**Is the survey conducted regularly, on a defined schedule?** *A single historical survey doesn't reflect current culture.* Doc: Survey schedule and history	YES	PARTIAL	NO
3	**Are survey results reviewed and acted on, with visible follow-up?** *Measurement without action provides no real improvement.* Doc: Results review and action record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Survey tool and history review*	Reviews the survey tool used for validation and checks the administration schedule for regularity.
DOCUMENT *Results and action review*	Reviews survey results and checks for evidence of genuine follow-up action, not just data collection.
ASK *Staff perception interview*	Asks staff whether they believe survey results actually lead to visible change.

REFERENCES

Safety culture surveys are a recognised patient safety measurement practice specifically because staff silence is an ambiguous signal that can indicate either genuine safety or suppressed concern, and only direct measurement distinguishes between them.