ACCRÉDITATION SANS FRONTIÈRES

ASF Priority Practices

The critical, cross-cutting safety practices every ASF-accredited organization must demonstrate, reviewed annually

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Foreword

ASF's seven organizational standards, taken together, run to hundreds of individual criteria. All of them matter — that is why they are published as requirements, not suggestions. But a small number of practices, drawn from across all seven standards, are serious and cross-cutting enough to warrant standing on their own: visible at a glance, checked in every survey regardless of facility type, and reviewed on a genuinely shorter cycle than ASF's full three-year standards revision.

This document does not create new requirements. Every practice listed here already exists as a criterion within one or more of ASF's seven organizational standards — this document elevates it, grounds it in the real, published global evidence behind why it matters, cross-references its full treatment, and commits ASF to reviewing it annually rather than waiting for the next full standards revision.

> *Both Accreditation Canada, through its Required Organizational Practices, and Joint Commission, through its National Patient Safety Goals, maintain an equivalent short, frequently updated list alongside their full standards. This document occupies the same position in ASF's own architecture.*

1. Purpose and Relationship to the Seven Standards

This document identifies practices that meet three conditions: the practice addresses a genuine, serious risk to patient, resident, or service-user safety; the risk is cross-cutting, relevant across most or all of ASF's seven organizational standards rather than specific to one facility type; and the practice is one where inconsistent implementation has been repeatedly identified, in the field generally, as a real source of preventable harm.

A practice appearing in this document is not thereby more legally binding than the same requirement stated in its home standard — both are equally mandatory. What changes is visibility and review frequency: a priority practice is checked in every survey and reviewed for currency every year, not folded into the general document review that occurs on the three-year cycle.

2. The Global Burden Behind This Document

This list is not built from intuition about which practices feel important. The World Health Organization identifies patient harm as the fourteenth leading cause of the global disease burden — comparable in scale to tuberculosis and malaria — with an estimated 421 million hospitalizations worldwide each year producing approximately 42.7 million adverse events [1]. In low- and middle-income countries specifically, hospitalizations are estimated to produce 134 million adverse events annually, contributing to 2.6 million deaths [2]. Patient harm is estimated to reduce global economic growth by 0.7 percent a year [1].

Each of the six practices in Section 3 corresponds to one of the specific, named categories of avoidable harm this global evidence base identifies as both common and preventable — not a general aspiration toward safety, but a response to a documented, measured burden.

3. The Priority Practices

P1 Correct Identification of Patients, Residents, or Service Users

Before providing any service, treatment, or medication, staff verify the identity of the person receiving care using at least two identifiers — never relying on room number, bed assignment, or visual recognition alone.

The evidence: *Patient misidentification is explicitly named by WHO among the common categories of avoidable adverse events documented across both developed and developing health systems [1], and is one of the specific failure points administrative and process errors in primary care alone have been found to account for in five to fifty percent of all recorded medical errors [3].*

Cross-reference: *Addressed within each ASF organizational standard's patient/resident safety and identification criteria.*

P2 Medication Safety

Organizations maintain a documented process for safe medication storage, administration, and reconciliation — including a specific, documented process for identifying and managing look-alike, sound-alike medications, and for reconciling medications at every transition in care.

The evidence: *WHO estimates medication-related harm affects approximately one in thirty patients receiving healthcare, with more than a quarter of that harm classified as severe or life-threatening, and estimates the global cost of medication errors at approximately US$42 billion annually [4–5]. This is the specific evidence base behind WHO's third Global Patient Safety Challenge, Medication Without Harm, launched in 2017 with the explicit goal of reducing severe avoidable medication harm by half within five years [5].*

Cross-reference: *Addressed within each ASF organizational standard's medication management criteria.*

P3 Infection Prevention and Control

Organizations maintain and demonstrate hand hygiene compliance, appropriate use of personal protective equipment, and a documented process for identifying and responding to a suspected outbreak, proportionate to the setting's actual infection risk.

The evidence: *Healthcare-associated infection affects an estimated fourteen out of every one hundred hospitalized patients globally — seven in high-income countries and ten in low- and middle-income countries — and is described by WHO as the most frequent adverse event in healthcare, despite its true global burden remaining difficult to measure precisely due to inconsistent surveillance capacity across health systems [6–7]. In the European Union alone, an estimated 3.2 million patients acquire a healthcare-associated infection annually, with 37,000 deaths as a direct consequence [4].*

Cross-reference: *Addressed within each ASF organizational standard's infection prevention and control criteria.*

P4 Communication During Care Transitions

Organizations maintain a structured, documented handoff process when responsibility for a patient, resident, or service user transfers between staff, shifts, or care settings — ensuring critical information is actively communicated and confirmed received, not merely documented in a record the receiving party may not read before care continues.

The evidence: *Communication failure during a care transition is repeatedly identified across the international patient safety literature as a contributing factor across multiple categories of adverse event — diagnostic error, medication error, and delayed recognition of patient deterioration among them [8].*

Cross-reference: *Addressed within each ASF organizational standard's care coordination and communication criteria.*

P5 Fall Prevention

Where relevant to the setting — long-term care, home care, and inpatient hospital settings specifically — organizations maintain a documented fall-risk assessment process and demonstrate specific preventive measures for individuals identified as at elevated risk.

The evidence: *Patient falls are named explicitly by WHO among the common, largely preventable adverse events occurring across health systems worldwide, with disproportionate impact in long-term care and home care settings where the population served carries elevated baseline fall risk [1, 8].*

Cross-reference: *Addressed within the Long-Term Care, Home Care, and Hospital standards' safety criteria.*

P6 Reporting and Responding to Sentinel Events

Organizations maintain, and staff understand, a documented process for identifying and reporting a sentinel event, consistent with the ASF Sentinel Event Policy. This priority practice is specifically about staff awareness and functioning process — not about whether a sentinel event has occurred, which is governed entirely by the Sentinel Event Policy itself, not assessed as a compliance criterion here.

The evidence: *A functioning, honestly used reporting culture is what allows the aggregate global evidence in Section 2 to exist at all — the WHO burden estimates cited throughout this document depend on health systems and facilities that actually identify and report adverse events, rather than concealing them.*

Cross-reference: *Full process governed by the ASF Sentinel Event Policy (ASF-SEP-001).*

4. How This List Is Maintained

4.1 Annual Review

This document is reviewed annually by the ASF International Standards Council — independent of, and more frequently than, the three-year revision cycle governing ASF's full organizational standards under Section 12 of How ASF Develops and Revises Standards.

4.2 Adding or Removing a Practice

A practice is added to this document only where it genuinely meets all three conditions in Section 1 — this list is deliberately kept short, and is not a mechanism for elevating every important requirement to priority status. A practice is removed where sustained evidence, gathered through ASF's own survey data and the aggregate learning function of the ASF Sentinel Event Policy, shows the risk it addresses is no longer a significant, recurring source of preventable harm across ASF's accredited network.

5. Surveyor Assessment of Priority Practices

Every ASF survey, regardless of which organizational standard is being applied, includes explicit assessment of the priority practices relevant to that setting, conducted by surveyors certified under the ASF Surveyor Training Standard. Priority practices are assessed using the same observation, interview, and document review methods applied to any other requirement — this document does not introduce a separate or lesser assessment method.

> *A priority practice that is only checked on paper, without direct observation of actual practice, has not genuinely been assessed. This is precisely why priority practices are folded into the standard survey methodology rather than treated as a separate checklist exercise.*

References

[1] World Health Organization. Patient Safety [fact sheet]. Geneva: WHO; 2023.

[2] Textbook of Patient Safety and Clinical Risk Management, Chapter: Patient Safety in the World. NCBI Bookshelf. 2020.

[3] International Alliance of Patients' Organizations. World Health Organization's 10 Facts on Patient Safety. London: IAPO; 2018.

[4] Kennedy Johnson. How Common are Medical Mistakes? Latest Hospital Error Statistics. 2026.

[5] World Health Organization. Medication Without Harm — Global Patient Safety Challenge. Geneva: WHO; 2017.

[6] World Health Organization. The Burden of Health Care-Associated Infection Worldwide. Geneva: WHO; 2010.

[7] World Health Organization. WHO Guidelines on Hand Hygiene in Health Care: First Global Patient Safety Challenge, Clean Care Is Safer Care. Geneva: WHO; 2009.

[8] NCBI. Poor Quality Care in Healthcare Settings: An Overlooked Epidemic. 2026.

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This document does not replace ASF's seven organizational standards — it makes six of their most critical, evidence-backed requirements impossible to overlook, and commits ASF to keeping both the list and its evidence genuinely current.