

Hospital Standards

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20 standards · 167 criteria · 94 non-negotiable · 47 core · 26 standard · Version 8.0

STANDARD 1 · MANDATORY

Access & Arrival

1.1 Findable Before Arrival

NON-NEGOTIABLE

The facility's name, address, phone number, and mapped location are correct, current, and independently verifiable by anyone searching as a patient would, and the range of services offered is published and kept current, not left for a prospective patient to discover only by calling or arriving in person.

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.
2. Does the phone number listed actually connect to your facility when called? — Tested directly, not assumed because it was correct when first published.
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.
4. Is the range of services the facility actually provides published somewhere a prospective patient can find it before contacting the facility, and kept up to date as services change? — Genuinely current public information, not a service list last updated years ago or only available by asking.

1.2 Hospital Grounds and Territory Entrance

NON-NEGOTIABLE

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.

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.
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.
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.

1.3 Physical Access, or a Real Plan

NON-NEGOTIABLE

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.

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.

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.
3. Has any real step already been taken toward that plan? — A quote obtained, materials ordered, or work scheduled — not just intention.

1.4 Emergency Entrance, Marked and Clear

NON-NEGOTIABLE

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.

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.
2. Is the route to it kept physically clear at all times? — Not just clear when checked — clear as a matter of routine.
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.

1.5 Wayfinding Without Staff Dependence

CORE

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.

1. Can a first-time visitor find reception using only your posted signage? — Not staff intercepting and redirecting.
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.
3. Is signage consistent across every floor, or does it stop after the ground floor? — A common, specific failure.

STANDARD 2 · MANDATORY

Reception & Information

2.1 Patients Know Their Rights

NON-NEGOTIABLE

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. The charter explicitly names privacy, dignity and respect, confidentiality, personal safety and security, how consent is granted, the right to refuse treatment, and recognition of the patient's cultural and spiritual preferences, including access to spiritual or religious care on request.

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.
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.
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.
4. Does the charter explicitly state the patient's right to refuse treatment, with staff able to describe what happens in practice when a patient exercises it, not only a listed right with no real process behind it? — A genuine, honoured right, not a line in a document with no defined practice for when a patient actually invokes it.
5. Is there a real, accessible process for a patient to request spiritual or religious care or accommodation of cultural practice, distinct from general cultural-awareness training for staff? — A specific, usable process a patient or family can actually invoke, not only staff sensitivity in the abstract.

2.2 Pricing Is Disclosed Before Care Begins

CORE

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

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.
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.
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.

2.3 Reception Desk Accessibility

NON-NEGOTIABLE

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.

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.
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.
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.

2.4 Health Information Is Genuinely Understandable, Not Just Provided

CORE

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.

1. Is health information routinely delivered in plain language, avoiding unexplained medical terminology? — Genuinely accessible language, not clinical terms used without explanation.
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.
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.

2.5 Waiting and Queue Time Is Actively Managed

CORE

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.

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.
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.
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.

STANDARD 3 • MANDATORY

Environment & Shared Spaces

3.1 Water Supply Is Safe and Monitored

NON-NEGOTIABLE

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

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.
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.
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.

3.2 Medical Equipment Is Maintained on Schedule

NON-NEGOTIABLE

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.

1. Is there a documented maintenance schedule covering all clinical equipment? — Not equipment maintained "as needed" or reactively — a defined, proactive schedule.
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.
3. Is there a named person or role responsible for the maintenance programme? — Responsibility spread across nobody in particular usually means it happens inconsistently.

3.3 Shared Spaces Are Genuinely Clean

CORE

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.

1. Is there a documented cleaning schedule for shared spaces, with records kept? — Not a general statement that cleaning happens — a specific, dated schedule.
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.
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.

3.4 Facility Risks Are Tracked in One Integrated Register

NON-NEGOTIABLE

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.

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.
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.
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.

3.5 An Environmental Sustainability Programme Is Genuinely Active

CORE

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.

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.
2. Is progress tracked against defined, measurable targets? — Real, trackable metrics, not an assumption that good intentions are sufficient.
3. Is there a named person or team responsible for the programme? — Specific ownership, not diffuse responsibility that belongs to nobody in particular.

3.6 Facility Signage Is Complete, Not Just Present at Reception

NON-NEGOTIABLE

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.

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.
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.
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.

STANDARD 4 · MANDATORY

Care & Treatment

4.1 Consent Is Real, Not a Signature

NON-NEGOTIABLE

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.

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.
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.
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.

4.2 Staff Credentials Are Checked and Current

NON-NEGOTIABLE

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 — and that staff member receives structured orientation before independent practice, periodic performance and competency evaluation thereafter, and is expected to practise according to current, accepted evidence-based standards, protocols and guidelines.

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.

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.
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.
4. Does every new clinical staff member complete structured orientation covering role-specific procedures before practising independently, not learn the job informally from colleagues as they go? — A real, structured orientation programme, not an assumption that shadowing a colleague for a few days is sufficient.
5. Is every clinical staff member's performance and competency formally evaluated on a defined schedule, documented and shared with the staff member, not left to informal supervisor impression? — A genuine, documented, periodic evaluation process, distinct from credential verification alone.
6. Can staff describe the current evidence-based guideline or protocol behind a specific clinical decision they made recently, not rely on personal habit or how it has always been done? — Genuine, demonstrated reliance on current accepted evidence, not inherited practice never revisited.

4.3 New Staff Are Properly Onboarded

NON-NEGOTIABLE

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

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.
2. Does induction happen before independent work begins, not alongside it? — Learning safety essentials while already working unsupervised defeats the purpose.
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.

4.4 Staffing Actually Matches Patient Need

NON-NEGOTIABLE

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.

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.
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.
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.

4.5 Hand Hygiene Actually Happens

NON-NEGOTIABLE

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

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.
2. Is compliance measured through genuine, unannounced observation, not self-report? — Staff self-report on hand hygiene is notoriously unreliable — this needs real observation.
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.

4.6 Protective Equipment Is Actually Available

NON-NEGOTIABLE

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.

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.
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.
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.

4.7 Sharps and Waste Are Handled Safely

NON-NEGOTIABLE

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.

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.
2. Are containers replaced before they reach unsafe fill levels, not left to overflow? — An overfilled container is a direct, preventable injury risk.
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.

4.8 Every Patient Gets a Real Assessment

NON-NEGOTIABLE

A structured clinical assessment happens on admission — a genuine evaluation using a defined process, not a chart entry completed to satisfy documentation requirements — performed by a qualified individual, drawing in other relevant disciplines where the patient's presentation calls for it, and documented as required by organisational policy.

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.
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.
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.
4. Is the assessment genuinely performed by someone qualified to perform it, verifiable against that person's credentialed scope, not delegated informally to whoever is available? — A named, qualified assessor, not an assessment completed by whoever happened to have a free moment.
5. Where the patient's presentation calls for it, does the initial assessment genuinely draw in other relevant disciplines, not remain confined to a single discipline's perspective regardless of complexity? — Real multidisciplinary input when the case warrants it, not a single-discipline assessment applied uniformly regardless of need.

4.9 There's an Actual Care Plan

NON-NEGOTIABLE

A documented, individualised care plan guides treatment — built from the patient's specific assessment, not a generic template applied regardless of their particular situation — states the goals or desired results of treatment, and involves the patient, and family when appropriate, in setting it.

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.
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.
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.

4. Does the care plan state explicit goals or desired results of treatment, not only a list of interventions with no stated purpose? — A genuine goal the plan is working toward, not just a record of what's being done.

5. Was the patient, and family where appropriate, genuinely involved in setting the plan's goals, not only informed of a plan decided without them? — Real involvement in setting direction, not notification after the plan is already fixed.

4.10 Medication Prescribing Is Safe

NON-NEGOTIABLE

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.

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.

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.

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.

4.11 The Surgical Safety Checklist Is Actually Used

NON-NEGOTIABLE

WHO's Surgical Safety Checklist is completed, out loud, as a genuine team pause for every procedure — not filed as paperwork after the fact — and includes explicit verification of correct patient, correct procedure, and correct body site, with the site physically marked before the patient enters theatre.

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.

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.

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.

4. For any procedure involving laterality, multiple structures, or multiple levels, is the surgical site physically marked by the operating clinician before the patient enters theatre, and is that mark visible and verified during the time-out? — Explicit site marking and verification, not an assumption that confirming the procedure name alone rules out wrong-site error.

4.12 Anaesthesia Is Delivered Safely

NON-NEGOTIABLE

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

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.

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.

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.

4.13 Surgical Site Infection Is Actively Prevented

NON-NEGOTIABLE

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

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.
2. Is the facility's own SSI rate actually measured and tracked? — Improvement isn't possible against a rate nobody is measuring.
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.

4.14 The Lab Has Quality Control

NON-NEGOTIABLE

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.

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.
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.
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.

4.15 Critical Lab Values Reach the Doctor Fast

NON-NEGOTIABLE

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.

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.
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.
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.

4.16 Specimens Are Correctly Identified

NON-NEGOTIABLE

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

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.
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.
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.

4.17 Medication Storage Is Secure and Correct

NON-NEGOTIABLE

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

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.

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.
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.

4.18 High-Alert Medications Get Extra Safeguards

NON-NEGOTIABLE

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.

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.
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.
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.

4.19 Medication Reconciliation Actually Happens

NON-NEGOTIABLE

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.

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.
2. Are discrepancies found during reconciliation actually resolved and documented, not just noted? — Identifying a discrepancy without resolving it provides no real safety benefit.
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.

4.20 Patient Identified Correctly at Every Point of Contact

NON-NEGOTIABLE

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.

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.
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.
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.

4.21 Falls Risk Assessed and Actively Prevented

NON-NEGOTIABLE

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.

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.
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.

3. Are falls tracked as a safety indicator, with each fall reviewed? — Tracking without review misses the chance to learn from each incident.

4.22 Look-Alike, Sound-Alike Medications Are Specifically Managed

CORE

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.

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.
2. Are LASA medications stored separately or distinctly labelled to prevent mix-up? — Physical or visual separation, not reliance on staff memory alone.
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.

4.23 Restraint and Seclusion Use Is Governed and Minimised

CORE

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.

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.
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.
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.

4.24 Nutrition and Therapeutic Diet Needs Are Actively Managed

CORE

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.

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.
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.
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.

4.25 Deteriorating Patients Are Caught Before the Crisis, Not After

NON-NEGOTIABLE

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.

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.
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."

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.

4.26 Sepsis Is Recognised and Treated Within the Hour

NON-NEGOTIABLE

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.

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.
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.
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.

4.27 Pressure Injury Risk Is Assessed and Actively Prevented

CORE

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.

1. Is every patient assessed for pressure injury risk on admission using a structured tool? — A validated risk assessment tool, not visual inspection alone.
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.
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.

4.28 VTE Risk Is Assessed Before Every Admission and Procedure

CORE

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.

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.
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.
3. Is appropriate prophylaxis actually prescribed and administered for patients identified as at-risk? — Identification without follow-through provides no real protection.

4.29 Blood and Blood Products Are Verified Before Every Transfusion

NON-NEGOTIABLE

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.

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.

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."
3. Is there a defined, immediate response protocol for a suspected transfusion reaction? — A specific, known process — not improvisation in the moment.

4.30 Handoffs Use a Structured, Verbal Process — Not Just a Written Note

NON-NEGOTIABLE

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.

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.
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.
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.

4.31 Opioid Prescribing Is Deliberately Stewarded

CORE

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.

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.
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.
3. Is there monitoring for signs of diversion or misuse, not just appropriate initial prescribing? — Stewardship extends beyond the prescribing moment into ongoing awareness.

4.32 Pain Is Formally Assessed and Reassessed, Not Just Asked About Once

CORE

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.

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.
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.
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.

4.33 Dignity, Respect, and Non-Discrimination Are Practised, Not Just Stated

NON-NEGOTIABLE

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.

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.
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.
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.

4.34 Vulnerable Patients Get Real, Specific Protections

NON-NEGOTIABLE

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.

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.
2. Do identified vulnerable patients receive specific, documented additional protections? — Concrete, named protections — not the same general care approach applied to everyone.
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.

4.35 Advance Directives Are Sought, Documented, and Actually Followed

CORE

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.

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.
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.
3. Is there evidence that documented directives actually influence care decisions when relevant? — Genuine adherence, not just documentation that exists but goes unconsulted.

4.36 The Facility Tracks Its Own Infection Rate Over Time

CORE

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.

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.

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.
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.

4.37 Medication Safety Doesn't Depend on Software That Isn't Actually Working

NON-NEGOTIABLE

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.

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.
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.
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.

STANDARD 5 • MANDATORY

Safety & Emergency Preparedness

5.1 Triage Actually Sorts Patients by Urgency

NON-NEGOTIABLE

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.

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.
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.
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.

5.2 Resuscitation Equipment Is Ready Right Now

NON-NEGOTIABLE

Resuscitation equipment is checked every shift, fully stocked and functional, and staff maintaining life support competency are genuinely current, not overdue for recertification.

1. Is resuscitation equipment checked every shift, with a documented record? — Not checked "regularly" — checked every single shift, verifiably.
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.
3. Are all relevant staff current on life support certification, not overdue? — A lapsed certification discovered only during an emergency is a preventable failure.

5.3 There's a Real Disaster Response Plan

NON-NEGOTIABLE

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.

1. Does a documented mass casualty and disaster response plan exist? — Specific to mass casualty and disaster scenarios, not a general emergency policy.
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.
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.

5.4 Fire Safety Is Real, Not Theoretical

NON-NEGOTIABLE

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.

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.
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.
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.

5.5 Workplace Violence Is Prevented, Not Just Responded To

NON-NEGOTIABLE

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.

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.
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.
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.

5.6 Internal Emergency Alerts Are Clear, Consistent, and Trained

NON-NEGOTIABLE

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.

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.
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.
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.

STANDARD 6 • MANDATORY

Aftercare & Follow-up

6.1 Every Discharged Patient Gets a Real Aftercare Plan

NON-NEGOTIABLE

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.

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.
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.
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.

6.2 A Real Mechanism Checks on the Patient After They Leave

NON-NEGOTIABLE

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.

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.
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.
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.

6.3 Patients Can Complain After Leaving, and Complaints Are Actually Read

NON-NEGOTIABLE

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.

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.
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.
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.

STANDARD 7 · MANDATORY

Governance & Management

7.1 The Board Is Real and Accountable

NON-NEGOTIABLE

A governing body exists, with named members and clear, documented authority over safety and quality, clinical governance, and financial stewardship — not an informal ownership arrangement functioning without real oversight structure.

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.
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.

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.
4. Is clinical governance — oversight of clinical effectiveness, audit, and risk — explicitly assigned to a named board responsibility, not left implicit within general quality oversight? — A distinct, named accountability for clinical governance, not assumed to be covered by discussing quality in general terms.
5. Is financial stewardship — budget oversight, financial risk, and resource allocation — a defined board responsibility distinct from day-to-day financial management? — Board-level financial oversight, not only operational finance handled by management alone.

7.2 There Is a Written Strategic Plan

NON-NEGOTIABLE

A documented plan states the hospital's mission, values, and a code of conduct for staff behaviour, and genuinely guides resourcing decisions — not a one-page mission poster disconnected from how money and staff time actually get allocated, and not a mission statement with no accompanying statement of values or expected conduct.

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.
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.
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.
4. Does the hospital have a documented statement of values and a code of conduct distinct from the mission statement, genuinely guiding staff behaviour rather than existing only as a wall display? — A real, specific statement of expected conduct, not a mission statement alone standing in for it.

7.3 Policy Actually Gets Followed

NON-NEGOTIABLE

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. The framework includes a formal, comprehensive quality improvement plan covering every part of the hospital, with allocated responsibilities and defined performance indicators.

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.
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.
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.
4. Is there a single, formal quality improvement plan comprehensive across governance, clinical governance, organisational management, utilisation and efficiency of services, and quality performance — with named responsibilities and defined indicators — rather than scattered, department-level efforts with no unifying plan? — See the ASF Indicator Programme for the recommended indicator set. A genuinely comprehensive plan, not isolated initiatives in individual departments.
5. Is the quality improvement plan itself formally evaluated on a defined schedule, with the evaluation used to revise the plan? — A plan that is reviewed and updated, not adopted once and left static.
6. Is every policy, procedure and plan formally authorised by a named person with the authority to approve it, with that authorisation genuinely recorded, not assumed because the document exists on a shared drive? — A recorded sign-off by someone with real authority to approve it, not a document that simply appeared without a traceable approval.
7. Is every policy, procedure and plan reviewed against a defined timescale to confirm it's still current, not left in place indefinitely once approved? — A genuine scheduled review date, not a document approved once and never revisited regardless of how outdated it becomes.

7.4 Patient Information Stays Private

NON-NEGOTIABLE

Confidentiality is protected physically and culturally throughout the facility, not only referenced in a written policy that doesn't translate into actual practice.

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.
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.
3. Do staff understand and apply confidentiality practices consistently, not only when reminded? — Tests whether privacy protection is habitual, not situational.

7.5 Medical Records Are Complete

NON-NEGOTIABLE

Records contain all mandatory elements and are genuinely audited for completeness on a regular basis, not assumed complete because a template exists.

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.
2. Are records regularly audited for completeness against that list? — Genuine audit, not assumption of completeness because a template was used.
3. Are gaps found during audits actually addressed, not just noted? — Identifying an incomplete record without correcting it leaves the underlying risk unresolved.

7.6 Patient Data Is Kept Secure

NON-NEGOTIABLE

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.

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.
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.
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.

7.7 Records Are Kept Exactly as Long as Required

NON-NEGOTIABLE

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.

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.
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.
3. Is disposal of records past their retention period conducted securely and documented? — Disposal that protects confidentiality even as the record is destroyed.

7.8 Incidents Are Actually Reported

NON-NEGOTIABLE

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.

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.

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.
3. Do staff believe they can report without fear of punitive consequence? — Genuine psychological safety, not just a stated non-punitive policy.

7.9 Serious Incidents Get Properly Investigated

NON-NEGOTIABLE

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.

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.
2. Does the RCA result in a specific, tracked action plan? — Findings without a resulting plan don't translate into prevention.
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.

7.10 Safety Culture Is Actually Measured

NON-NEGOTIABLE

A validated survey measures whether staff genuinely feel safe raising concerns, conducted regularly and acted on, not assumed from the absence of complaints.

1. Is a validated safety culture survey conducted, not an informal or ad hoc check? — A recognised, validated tool, not an internally improvised questionnaire.
2. Is the survey conducted regularly, on a defined schedule? — A single historical survey doesn't reflect current culture.
3. Are survey results reviewed and acted on, with visible follow-up? — Measurement without action provides no real improvement.

7.11 Patient Experience Is Measured Continuously, Not Only After Discharge

CORE

Patient experience is measured through structured, ongoing feedback during the course of care — not only through the post-discharge complaint channel required elsewhere in this document, which by definition only captures concerns raised after the fact.

1. Is patient experience measured through structured feedback during the stay, not only after discharge? — Real-time or near-real-time feedback, distinct from the post-discharge complaint channel.
2. Is feedback collected broadly, not only from patients who happen to volunteer it? — A systematic approach, not reliance on the small subset of patients naturally inclined to give feedback.
3. Is collected feedback actually reviewed and used to inform real improvements? — Genuine responsiveness, not data collected and left unexamined.

7.12 A Real Ethics Consultation Process Exists

CORE

Staff facing a genuine ethical dilemma in patient care have access to a real, usable ethics consultation process — a committee, a named resource, or an external arrangement — not left to resolve difficult cases alone or through informal corridor conversations.

1. Is there a real, accessible ethics consultation process — committee, named resource, or external arrangement? — An actual, usable resource, not a theoretical statement that ethical principles matter.
2. Do staff know how to access it, not just that it exists somewhere in policy? — Practical, known accessibility — staff can describe how they'd actually use it.
3. Has the process actually been used for a real case, or does it exist only theoretically? — Genuine use is the real test of whether this is a functioning resource or a document nobody has needed to open.

7.13 Patients and Families Have a Real Voice in Governance

CORE

At least one patient or family representative has a genuine, structured role in quality review or governance discussions — not a governance and quality structure that is entirely staff and board-facing, with patient input arriving only indirectly through complaints or surveys.

1. Does at least one patient or family representative have a genuine, structured role in quality review or governance discussions? — An actual seat or defined role, not indirect input filtered through staff-collected feedback alone.
2. Is this representative genuinely included in discussion, not present only as an observer? — Real participation, not token attendance without a voice in the discussion.
3. Can the facility point to a specific instance where patient or family input shaped a real decision? — Concrete evidence of influence, not just presence.

STANDARD 8

Medical Tourism

8.1 Pricing Transparency for International Patients

NON-NEGOTIABLE

International patients receive a complete, written, all-inclusive cost estimate before travel is booked — covering the procedure, hospital stay, and commonly needed extras — not a partial quote that grows once the patient has already committed to travelling.

1. Is a complete, written cost estimate provided before the patient books travel? — Before travel is booked, not after arrival — the point where the patient still has a real choice.
2. Does the estimate cover commonly needed extras, not just the base procedure? — Anaesthesia, extended stay, common complications — the items that turn a quoted price into a real surprise.
3. Can a recent international patient confirm the final cost matched the estimate, or that any difference was clearly explained in advance? — Tests whether the estimate was honest, not just early.

8.2 Remote Records Transfer to Home-Country Physician

NON-NEGOTIABLE

A complete, usable record of the care provided is transferred to the patient's home-country physician, in a format that physician can actually use — not a discharge summary that stays in the treating facility's own system.

1. Is a complete treatment record transferred to the patient's home-country physician, not just given to the patient to pass along? — Direct transfer, not relying on the patient to correctly deliver and explain their own paperwork.
2. Is the record provided in a language and format the home physician can genuinely use? — Translated where needed, not just exported in the treating facility's own internal format.
3. Is transfer confirmed as received, not just sent? — A record sent into an unconfirmed inbox provides no more protection than no record at all.

8.3 Language Access for Foreign Patients

NON-NEGOTIABLE

Foreign patients have access to a genuinely competent interpreter for consent, treatment discussions, and discharge instructions — not an ad hoc arrangement using whichever staff member happens to speak some of the patient's language.

1. Is a genuinely competent interpreter — professional or trained — used for consent and major treatment discussions? — Not whichever staff member happens to speak some of the language informally.
2. Are discharge instructions specifically covered through proper language access, not simplified or skipped due to language barriers? — Discharge is exactly the point where miscommunication causes the most post-return harm.

3. Can the facility name which languages it can genuinely support, and what happens when a patient's language isn't covered? — A specific, honest answer, not a general assurance language is never a problem.

8.4 Travel, Accommodation, and Logistics Coordination

CORE

The facility provides or coordinates genuine support for travel and accommodation logistics around the procedure — not leaving an international patient, often recovering from treatment, to navigate this entirely alone in an unfamiliar country.

1. Does the facility provide or coordinate genuine support for accommodation appropriate to the patient's recovery needs? — Matched to actual recovery requirements, not a generic hotel list handed over without guidance.
2. Is local transport between accommodation and the facility genuinely arranged or clearly explained? — Not assumed the patient will figure out local transport independently while recovering.
3. Is there a named point of contact for logistics questions during the patient's stay? — A specific person or service the patient can actually reach, not a general inquiry line.

8.5 Post-Return Complication Tracking

NON-NEGOTIABLE

The facility actively tracks what happens to international patients after they return home — including complications discovered by a home-country physician — not just relying on a generic follow-up call that a satisfied patient may not bother answering.

1. Is there a specific, active mechanism to learn about complications discovered after a patient returns home? — Beyond a generic satisfaction call — a real channel for the patient's home physician or the patient themselves to report a problem.
2. Does the facility request feedback from the patient's home physician, not only the patient? — A home physician is often better positioned to identify a genuine complication than the patient describing symptoms informally.
3. Are post-return complications, when identified, tracked and reviewed as a quality indicator? — Tracking without review misses the chance to improve future international patient care.

8.6 Visa and Embassy Support Documentation

CORE

The facility provides the specific documentation international patients need for medical visa applications and embassy requirements, correctly and promptly — not generic paperwork that leaves the patient to figure out what's actually required themselves.

1. Does the facility know the specific visa and documentation requirements for the countries its patients most commonly travel from? — Specific, current knowledge, not general awareness that visas are sometimes needed.
2. Are required documents provided correctly and promptly, avoiding delays that could affect a patient's ability to travel in time? — Timeliness matters especially for clinically urgent cases.
3. Is there a named person responsible for visa and embassy documentation support? — Specific ownership, not a task that falls to whoever happens to have time.

8.7 International Patient Complaint and Redress Process

NON-NEGOTIABLE

International patients have access to a genuine complaint and redress process reachable from their home country, with real evidence complaints are addressed — not a process that functionally only works for a patient still physically present in the country.

1. Can an international patient submit a complaint from their home country, in a language they can use? — Genuinely reachable remotely, in a language the patient can actually communicate in.

2. Is there evidence international patient complaints are actually reviewed and result in a response? — Not just receipt acknowledgment — a substantive response addressing the actual concern.
3. Does the process account for the practical difficulty of an international patient providing follow-up information or documentation from abroad? — A process designed only for local patients can create unreasonable barriers for someone no longer in the country.

8.8 Facilitator and Agent Verification

NON-NEGOTIABLE

Any third-party medical tourism facilitator or agent the facility works with is verified and held to a defined standard of conduct — not an unregulated intermediary operating without any accountability to the facility or the patient.

1. Does the facility maintain a list of verified facilitators and agents it actually works with? — A specific, maintained list, not an open, unmonitored referral relationship with anyone claiming to be an agent.
2. Is there a defined standard of conduct facilitators must meet, covering accurate representation of costs, risks, and outcomes? — A specific, communicated standard, not an assumption that facilitators will represent things accurately on their own.
3. Is there a process for addressing a facilitator found to have misrepresented information to a patient? — A defined consequence, not an unaddressed pattern of misrepresentation.

8.9 Travel-Associated Infection Risk Protocol

NON-NEGOTIABLE

International patients are assessed for travel-associated infection risk specific to their journey and country of origin, with appropriate screening and precautions applied — not treated identically to a local patient with no recent travel history.

1. Is there a specific screening protocol for travel-associated infection risk applied to international patients? — Beyond standard admission screening — specific attention to recent travel and country-of-origin risk factors.
2. Does screening account for country-specific resistance patterns where relevant? — Generic screening can miss risks specific to certain regions or recent healthcare exposure abroad.
3. Are appropriate precautions applied based on screening results, not just documented and set aside? — Findings that don't change practice provide no real protection.

8.10 Post-Procedure Travel Timing and Venous Thromboembolism Risk

NON-NEGOTIABLE

Every international patient receives a specific, documented discussion of safe travel timing after their procedure — including the elevated blood clot risk from combining recent surgery with air travel — not a general assumption that the patient will figure out when it is safe to fly home.

1. Does every international patient receive a specific, documented discussion of safe travel timing for their specific procedure? — A specific, procedure-appropriate discussion, not a generic travel disclaimer.
2. Is the discussion specific to blood clot risk from combining this procedure with air travel, not general recovery advice? — The specific risk named directly, not folded into general aftercare instructions.
3. Can the patient explain back the recommended minimum time before flying, specific to their own procedure? — Tests genuine understanding specific to this patient, not general awareness that travel timing matters.

STANDARD 9

Refugee & Migrant Health

9.1 People-Centred Care Adapted to Migration and Displacement Experience

NON-NEGOTIABLE

Care is genuinely adapted to a patient's migration and displacement experience — including trauma-informed practice, awareness of legal-status barriers to access, and support for continuity of care — not delivered identically regardless of that history.

1. Are staff trained to adapt their practice based on a patient's migration and displacement experience, not deliver identical care regardless of history? — Genuine adaptation, not a generic cultural-awareness statement.
2. Is trauma-informed practice applied, including not routinely asking for detailed trauma history at initial visits? — WHO specifically advises against probing for detailed trauma history early in care.
3. Does the facility support continuity of care regardless of a patient's legal status? — Access not conditioned on documentation the patient may not have or be able to safely provide.

9.2 Supporting Patient Agency Through Genuine Understanding of Care and the Health System

NON-NEGOTIABLE

Patients are supported to genuinely understand both their own care and how to navigate the health system itself — with understanding actively verified through methods like teach-back, in plain language, not assumed from silence, a nod, or general goodwill information about the system.

1. Is understanding actively checked using a teach-back approach, for both the immediate care plan and how to navigate the system, not assumed from a nod? — Asking the patient to explain both back in their own words, not just asking "do you understand?"
2. Is concrete, practical guidance provided on navigating this health system specifically — appointments, referrals, emergency versus routine care? — Real navigation guidance, not just general encouragement to seek care.
3. Is information communicated in plain language, avoiding medical jargon, particularly when working through an interpreter? — Complex terminology strains interpretation and comprehension together.

9.3 Language and Communication Aids — Interpreters and Cultural Mediators

NON-NEGOTIABLE

Trained interpreters or cultural mediators are engaged for language-discordant consultations — never minor children, and only family members when genuinely no other option exists and the situation is not high-risk.

1. Are trained interpreters or cultural mediators engaged for language-discordant consultations? — Not ad hoc bilingual staff or family members as the default.
2. Is a minor ever used to facilitate interpretation for a family member? — This should never happen — a specific, absolute rule, not a judgement call.
3. When a family member interprets due to genuine unavailability of a trained interpreter, is this reserved for low-risk situations only? — Not used for informed consent, complex care, competency assessment, or bad news — situations WHO specifically flags as requiring professional language support.

9.4 Collaborative Practice Across Health and Social Services

CORE

The facility actively engages with legal, education, employment, housing, and other social support services relevant to refugee and migrant patients, and conducts effective handover of care that includes migration- and displacement-related context — not treating health care as isolated from these interconnected factors.

1. Does the facility have working relationships with relevant legal, housing, or social support services for referral? — Actual working relationships, not just awareness that such services theoretically exist.

2. Does handover of care to another provider include migration- and displacement-related context, not just clinical facts? — Cultural, language, and migration context specifically included in handover.
3. Are staff from refugee or migrant backgrounds, where present, genuinely utilised for their relevant skills and insight? — Recognising this as a specific asset, not incidental to their role.

9.5 Surge Capacity for Migration-Related Demand

NON-NEGOTIABLE

The facility has a real, activatable plan for responding flexibly to sudden increases in demand from migration or displacement events — expansion of assessment points, treatment distribution, and focus on critical needs — not an assumption that routine capacity will simply absorb any surge.

1. Does the facility have a specific, written plan for surge response to migration-related demand increases? — A specific plan, not a general assumption that staff will manage if it happens.
2. Has this plan actually been tested or exercised, not just written and filed? — An untested plan's real gaps remain unknown until an actual surge reveals them.
3. Does the plan address staff wellbeing and burnout risk during a surge, not only operational capacity? — Sustained surge response carries real staff mental health risk that a purely operational plan can miss.

9.6 Evidence-Informed Care for Refugee and Migrant Populations

CORE

Staff use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where evidence gaps remain, and adapt practice accordingly — not applying general population guidelines uncritically to a population with documented, different health needs.

1. Do staff have access to and use evidence-informed guidelines specific to refugee and migrant health, where they exist? — Specific guidance, not just general clinical guidelines applied without adaptation.
2. Can staff describe how refugee and migrant health needs may differ from the general population for conditions they commonly treat? — Genuine awareness of specific, relevant differences, not a general acknowledgment that differences might exist.
3. Is there a process for identifying and responding to gaps in evidence specific to this population? — Recognising uncertainty is itself part of good practice here, not something to paper over.

9.7 Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

NON-NEGOTIABLE

Staff maintain active awareness of their own culture, beliefs, and potential biases through structured reflective practice, and the facility actively fosters a supportive team environment with genuine access to psychological support — not assumed self-awareness or an assumption that staff will manage vicarious trauma exposure on their own.

1. Does the facility have a structured process for staff reflective practice regarding bias and cultural awareness? — A defined process, not an assumption that staff will naturally self-reflect adequately.
2. Does the facility provide genuine, accessible psychological support and a structured space to debrief difficult cases? — Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.
3. Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves or colleagues? — Genuine, concrete examples, not general statements of good intentions or awareness.

9.8 Cross-Border Continuity of Care

NON-NEGOTIABLE

Patients are supported to hold their own health information and documentation in a portable form — paper or electronic — that functions when they move across a border or between health systems, recognising the genuine mobility of refugee and migrant populations.

1. Are patients given their own portable health record, in a form they can carry with them? — Something the patient physically or digitally holds themselves, not only a record in the facility's internal system.
2. Is the record kept updated as care continues, not given once and left static? — An outdated record loses much of its value for continuity of care.
3. Does the record include information — medication history, vaccination record — that would be genuinely useful to a different provider in a different country? — Content specifically useful across a border, not just internally relevant notes.

9.9 Camp-Based and Non-Camp Service Model Fit

NON-NEGOTIABLE

The facility explicitly identifies which service model it operates under — formal camp, informal urban settlement, reception or transit centre, or established resettlement context — and demonstrates its practices are genuinely fit for that specific context, not a generic approach applied uniformly regardless of setting.

1. Can the facility clearly state which service model it operates under, and why that classification fits its actual context? — A specific, considered answer, not an assumption that one generic approach applies everywhere.
2. Are the facility's specific practices — staffing, scheduling, outreach — genuinely adapted to that model, not copied from a different context? — Real adaptation, not a generic template applied regardless of actual setting.
3. Has the facility considered what changes if its population or context shifts between models over time? — Genuine preparedness for a changing situation, not an assumption the current model is permanent.

9.10 Legal Status Diversity Recognition

NON-NEGOTIABLE

The facility can name which legal status categories it actually serves — asylum seeker, recognised refugee, stateless person, internally displaced person, and others — and demonstrates it doesn't apply a single, uniform assumption about access rights across all of them.

1. Can staff name the different legal status categories among the patients this facility actually serves? — Specific awareness of asylum seeker, refugee, stateless, and internally displaced distinctions relevant to this context.
2. Does the facility apply a single, uniform assumption about access rights, or does it recognise genuine differences by status? — Genuine differentiation where it legally matters, not a one-size-fits-all approach.
3. Are staff aware of the particular vulnerabilities that can attach to a specific legal status, such as statelessness? — Specific, not generic, awareness of status-linked risk.

STANDARD 10

Rehabilitation

10.1 Individualized Rehabilitation Plan Based on Functional Assessment

NON-NEGOTIABLE

Every patient receiving rehabilitation services has an individualized plan built from a documented functional assessment, not a generic protocol applied regardless of the patient's specific impairment and baseline function.

1. Is a documented functional assessment actually performed before the rehabilitation plan is built, not a generic protocol applied by diagnosis alone? — Two patients with the same diagnosis can have very different functional starting points.
2. Is the plan genuinely individualized to that assessment, not a standard template with the patient's name filled in? — Verified by comparing several patient plans for genuine difference, not just name changes.

3. Is the plan reassessed and adjusted as the patient's function changes during the course of treatment? — A plan fixed at admission may no longer reflect the patient's progress weeks later.

10.2 Multidisciplinary Team Coordination

NON-NEGOTIABLE

Rehabilitation care is coordinated across the relevant disciplines — physical therapy, occupational therapy, speech-language therapy, rehabilitation medicine, nursing, as applicable to the patient — through a genuine shared process, not separate disciplines working in isolation from each other.

1. Is there a genuine shared coordination process — a joint case conference, a shared plan document — not just separate disciplines each documenting independently? — Isolated discipline-specific notes with no shared coordination point is a common, specific failure.
2. Does coordination happen on a defined, recurring schedule, not only at admission and discharge? — A patient's course can change significantly between admission and discharge without interim coordination.
3. Can staff from different disciplines describe a specific instance where coordination changed the care plan? — Evidence the coordination process genuinely functions, not just exists as a scheduled meeting.

10.3 Patient and Family Goal-Setting and Education

CORE

Rehabilitation goals are set collaboratively with the patient and, where appropriate, family, in understandable terms, with the patient and family genuinely informed of realistic expectations — not goals set unilaterally by the clinical team.

1. Are goals documented as genuinely collaborative, with the patient's own input visible, not set unilaterally by staff? — A goal-setting record showing only clinical input, with no patient voice, suggests a one-way process.
2. Are realistic expectations genuinely communicated, not an overly optimistic picture that sets the patient up for disappointment? — Honest, calibrated communication, not false reassurance.
3. Is the patient able to describe their own rehabilitation goals in their own words when asked? — If the patient can't articulate the goals, the collaborative process likely wasn't genuine.

10.4 Progress Measured with Validated Functional Outcome Tools

CORE

Rehabilitation progress is tracked using a validated functional outcome measurement tool appropriate to the patient's condition, applied consistently at defined intervals, not relying on informal clinical impression alone.

1. Is a validated, recognized outcome tool actually used, not an informal, ad hoc progress note? — A validated tool provides a consistent, comparable measure; informal notes don't.
2. Is the tool applied at defined, consistent intervals, not sporadically whenever convenient? — Irregular measurement makes genuine progress tracking difficult.
3. Do outcome measurements actually inform changes to the treatment plan, or are they recorded without influencing care? — Measurement that doesn't feed back into the plan is documentation for its own sake.

10.5 Equipment and Assistive Device Provision Matches Need

CORE

Assistive devices and equipment — mobility aids, orthotics, adaptive equipment — are assessed, fitted, and provided to match the patient's actual functional need, with patient and caregiver trained in correct use before discharge.

1. Is equipment provision based on a documented individual assessment, not a default or convenience-driven choice? — Whatever's readily in stock, rather than what genuinely fits the patient's need, is a specific, checkable gap.

2. Are patient and caregiver actually trained in correct use before discharge, not just handed the equipment? — Equipment without genuine training in its use risks being unsafe or unused.
3. Is there a documented process for follow-up if the equipment later proves a poor fit? — A fitting assessed once at discharge may not remain appropriate as the patient's needs evolve.

10.6 Discharge and Community Reintegration Planning

STANDARD

Discharge planning for rehabilitation patients begins early in the course of treatment and genuinely addresses home environment, caregiver support, community resources, and follow-up therapy — not a last-minute checklist completed at the point of discharge.

1. Does discharge planning genuinely begin early in the treatment course, not only in the final days before discharge? — Early planning allows time to actually address gaps, such as a home environment needing modification.
2. Does the plan specifically address the patient's actual home environment and caregiver support, not generic discharge instructions? — A home with stairs and no support, for a patient with limited mobility, is a specific, checkable risk.
3. Is follow-up therapy or community resource connection actually arranged, not just recommended verbally? — A verbal recommendation with no actual referral or appointment often doesn't result in follow-through.

STANDARD 11

Critical Care

11.1 Continuous Physiological Monitoring Appropriate to Acuity

NON-NEGOTIABLE

Every critical care patient is continuously monitored with equipment and alarm parameters individually set to their clinical condition, with alarms genuinely responded to, not silenced or ignored due to alarm fatigue.

1. Are alarm parameters individually set for each patient's actual condition, not left on generic factory defaults? — Generic defaults can be clinically meaningless for a specific patient's baseline.
2. Is there a documented, genuine response time standard for alarms, verified against actual practice? — Alarm fatigue, where frequent alarms lead to delayed or absent response, is a well-documented critical care risk.
3. Is monitoring equipment checked and calibrated on a fixed schedule, with a documented process for equipment failure? — Equipment failure in critical care carries immediate, serious risk.

11.2 Nurse-to-Patient Ratio Matches Acuity

NON-NEGOTIABLE

A defined nurse-to-patient ratio appropriate to critical care acuity is maintained at all times, including nights and weekends, with a documented escalation process when staffing falls below the required ratio — not an aspirational standard that quietly erodes under pressure.

1. Is the defined ratio actually maintained, verified against real staffing records across different shifts, not just daytime weekday staffing? — Off-hours staffing pressure is a common, specific point where ratios erode.
2. Is there a documented escalation process when staffing falls below the required ratio? — Not an informal expectation that staff will manage, but a real, actionable escalation path.
3. Is there a documented instance of this escalation process actually being used? — Evidence the process functions in practice, not just exists on paper.

11.3 Rapid Response and Deterioration Recognition System

NON-NEGOTIABLE

A structured early-warning scoring system is used to detect patient deterioration, with a defined rapid response mechanism that staff can activate directly, without needing to escalate through multiple layers before genuine help arrives.

1. Is a structured, scored early-warning system actually used, not informal clinical impression alone? — A structured tool catches early deterioration more reliably than impression alone.
2. Can any staff member activate the rapid response directly, without needing multiple layers of approval first? — A response requiring lengthy escalation before activation undermines the purpose of a rapid response system.
3. Is there a documented, verified response time from activation to the responding team's arrival? — An assumed response time, never actually measured, often proves more optimistic than reality.

11.4 Sedation and Delirium Management Protocol

CORE

A written protocol governs sedation level targets and delirium screening for critical care patients, with sedation minimized to the clinically necessary level and delirium actively screened for on a defined schedule, not assumed absent without active checking.

1. Is sedation level actually targeted to a defined, documented goal, not a default "keep comfortable" approach without a specific target? — Deeper sedation than clinically necessary carries its own documented risks.
2. Is delirium actively screened for using a validated tool on a defined schedule, not just noticed informally if obvious? — Delirium can be subtle, particularly the hypoactive form, and is frequently missed without active screening.
3. Does a positive delirium screen trigger a documented clinical response, not just a note in the chart? — Detection without a genuine response provides limited protective value.

11.5 Family Communication and Presence Policy

CORE

A structured process ensures family receives regular, understandable updates on the patient's condition, with a clear, genuinely applied family presence policy — not family access or communication left to vary by which staff member happens to be on shift.

1. Do families receive genuinely regular updates in understandable terms, not sporadic updates that depend on which clinician happens to be available? — Inconsistent communication is a well-documented source of family distress in critical care.
2. Is the family presence policy applied consistently, not varying significantly by which staff member is on shift? — A policy applied inconsistently functions, in practice, as no real policy at all.
3. Is there a structured process for a family conference at defined clinical points, such as a significant change in prognosis? — A proactive structured conversation, not communication that happens only if family specifically asks.

11.6 End-of-Life and Withdrawal of Care Protocol

STANDARD

A written protocol governs end-of-life decision-making and withdrawal of life-sustaining treatment in critical care, including family involvement, ethics consultation access, and palliative support — not decisions made inconsistently depending on the individual clinician's own approach.

1. Does a written protocol genuinely guide end-of-life decision-making, not left to vary significantly by individual clinician approach? — Significant unexplained variation in approach between clinicians is a specific, checkable gap.
2. Is ethics consultation genuinely accessible when needed, not a resource that exists on paper but is rarely actually used? — Verified against actual recent use, not only the existence of an ethics committee.

3. Is palliative support genuinely integrated, not treated as a separate referral that happens only after active treatment has fully stopped? — Palliative support alongside, not only after, active treatment decisions.

STANDARD 12

Organ & Tissue Transplant

12.1 Donor Consent Obtained Through a Process Independent of the Transplant Team

NON-NEGOTIABLE

Donor or donor-family consent for organ or tissue donation is obtained through a process genuinely independent of the transplant team requesting the organ, with the independence structurally built in — not a theoretical separation undermined by the same staff being involved in both roles.

1. Is the person obtaining consent genuinely organizationally separate from the transplant team, not just nominally distinct while reporting to the same leadership? — A structural, not just a titular, separation is what actually protects against conflict of interest.
2. Is there a documented process ensuring the family or donor is never approached by someone with a direct stake in the transplant outcome? — The specific person requesting consent should have no personal or professional interest in a "yes" answer.
3. Can staff describe this separation clearly and confidently when asked? — If staff can't articulate how the separation works, it may not be genuinely built into practice.

12.2 Organ Allocation Follows a Transparent, Documented Protocol

NON-NEGOTIABLE

Organ allocation decisions follow a written, transparent protocol based on clinical criteria, applied consistently, with any deviation from the standard protocol specifically documented and justified — not informal decisions vulnerable to undue influence.

1. Does a written protocol genuinely govern allocation decisions, not informal judgment applied case by case? — A written, consistent protocol is a specific, checkable safeguard against undue influence.
2. Is any deviation from the standard protocol specifically documented with a clear clinical justification? — An undocumented deviation is a specific, checkable gap that undermines the protocol's purpose.
3. Is the allocation protocol and decision record available for independent review? — Genuine transparency means a decision can actually be reviewed, not just exist on paper.

12.3 No Financial Incentive to Donor or Family

NON-NEGOTIABLE

No financial payment or material incentive, beyond legitimate reimbursement of documented direct costs, is offered to a donor or donor family in connection with organ or tissue donation, with staff trained to recognize and refuse any such arrangement.

1. Is there a clear, written policy explicitly prohibiting financial incentive beyond legitimate documented cost reimbursement? — A specific, written prohibition, not an assumed understanding.
2. Are staff trained to recognize what counts as a legitimate reimbursement versus a prohibited incentive? — The distinction needs to be concrete and understood, not left to individual judgment in the moment.
3. Is there a documented process for reporting any suspected violation of this policy? — A real, actionable reporting pathway, not just a policy statement with no mechanism behind it.

12.4 Recipient Evaluation and Informed Consent Process

CORE

Transplant recipients undergo a documented evaluation against clinical eligibility criteria, with genuine informed consent covering realistic outcomes, risks, and the source of the organ or tissue where legally and clinically relevant — not a general surgical consent treated as sufficient.

1. Is recipient evaluation against clinical eligibility criteria actually documented, not assumed from referral alone? — A referral for transplant evaluation is not the same as a documented eligibility determination.
2. Does informed consent genuinely cover realistic outcomes and risks specific to transplant, not a generic surgical consent form? — Transplant carries specific risks and realistic outcome ranges that a generic surgical consent doesn't address.
3. Is the recipient's understanding genuinely verified, not just a signature obtained? — A signature confirms a form was signed, not that the content was genuinely understood.

12.5 Organ and Tissue Traceability, End to End

CORE

Every organ or tissue is traceable through a documented chain of custody from donor to recipient, including handling, testing, and transport, with no gap in the record at any point in that chain.

1. Is there an actual, continuous chain of custody record, with no gap at any handling point? — A single gap in the chain undermines the entire traceability purpose.
2. Does the record include testing and screening results specific to that organ or tissue, not just a general log entry? — Specific, retrievable results, not a generic pass/fail note.
3. Can the full chain be reconstructed on request for a specific organ or tissue? — Genuinely retrievable on demand, not theoretically traceable but practically difficult to reconstruct.

12.6 Post-Transplant Follow-Up and Outcome Tracking

STANDARD

Transplant recipients are followed systematically after the procedure, with graft and patient outcomes tracked and reported, not lost to follow-up once the recipient is discharged from the immediate post-operative period.

1. Is there a documented, systematic follow-up schedule, not informal contact depending on the recipient's own initiative? — A real, proactive schedule, not reliance on the recipient to seek follow-up themselves.
2. Are graft and patient outcomes actually tracked and aggregated, not scattered across individual, unconnected patient files? — Aggregated tracking enables the program to genuinely monitor its own outcomes over time.
3. Is there a documented process for what happens when a recipient is lost to follow-up? — A specific, active process for re-engagement, not simply accepting the loss.

STANDARD 13

Radiology

13.1 Radiation Dose Optimization and Justification

NON-NEGOTIABLE

Every imaging study involving ionizing radiation is clinically justified before ordering, with dose optimized to the lowest level consistent with diagnostic quality, not a default protocol applied regardless of patient size, age, or clinical indication.

1. Is clinical justification actually documented before the study is performed, not assumed from the order alone? — An order placed is not the same as a documented clinical justification for that specific radiation exposure.
2. Are dose protocols adjusted for patient size and age, particularly for pediatric patients, not a single adult default applied to everyone? — A pediatric patient given an adult-dose protocol receives meaningfully excess radiation exposure.
3. Is actual delivered dose tracked and reviewable, not just the protocol setting assumed to reflect what was delivered? — Verified against actual dose records, not only the intended protocol.

13.2 Equipment Quality Assurance and Calibration

NON-NEGOTIABLE

All imaging equipment undergoes documented quality assurance testing and calibration on a defined schedule by qualified personnel, with any equipment failing to meet standards immediately removed from clinical use until corrected.

1. Is quality assurance testing actually performed on schedule, verified against real completion records, not just a schedule that exists on paper? — A testing schedule that's routinely missed is not functioning.
2. Is equipment failing quality standards immediately removed from clinical use, not kept in service while awaiting repair? — Continued use of equipment known to be out of calibration is a specific, direct patient safety risk.
3. Is testing performed by genuinely qualified personnel, verifiable through credentials, not informally by whoever is available? — Quality assurance testing requires specific technical qualification, not general staff availability.

13.3 Timely, Accurate Reporting with Critical Finding Escalation

NON-NEGOTIABLE

Imaging studies are reported within a defined time frame appropriate to clinical urgency, with a documented, genuinely functioning critical finding communication protocol ensuring an urgent result reaches the ordering clinician directly, not left in a queue for routine review.

1. Is reporting turnaround time actually tracked and meeting defined targets, not assumed to be adequate? — Verified against real turnaround data, not a general sense that reports "go out quickly enough."
2. Does a critical finding trigger genuine, direct, documented communication to the ordering clinician, not just entered into the standard reporting queue? — A critical finding left in a routine queue can go unnoticed for a dangerously long period.
3. Is there a documented instance of the critical finding protocol actually being used? — Evidence the protocol genuinely functions, not just exists on paper.

13.4 Contrast Media Safety Protocol

CORE

A written protocol governs contrast media use, including pre-screening for allergy and renal function, informed consent, and a documented, immediately accessible emergency response plan for a contrast reaction — not a generic allergy question treated as sufficient screening.

1. Does pre-screening genuinely cover both allergy history and renal function, not a generic "any allergies?" question alone? — Renal function specifically matters for contrast safety and is easy to overlook without a specific check.
2. Is emergency response equipment and medication for a contrast reaction immediately accessible at the point of care, not stored elsewhere requiring retrieval time? — A contrast reaction can develop rapidly; retrieval delay for emergency response equipment is a specific, direct risk.
3. Are staff drilled on the emergency response protocol, not only given it as a reference document? — A drilled response functions differently under real stress than one only read about.

13.5 MRI Safety Screening and Zone Control

CORE

Every patient and accompanying individual is screened for MRI contraindications before entering the magnetic field, with physical zone control preventing unscreened access — not a screening form completed but not actually verified before entry.

1. Is screening genuinely verified before entry into the magnet room, not just a form completed somewhere earlier in the process? — A completed form that isn't actually checked at the point of entry provides no real protection.

2. Does physical zone control genuinely prevent unscreened individuals from entering, not relying solely on a sign or verbal instruction? — A physical barrier or access control, not just a posted warning, is the genuine safeguard.
3. Are accompanying individuals — not just the patient — also genuinely screened? — A family member or support person entering unscreened carries the same risk as an unscreened patient.

13.6 Image and Report Retention, Accessible for Comparison

STANDARD

Imaging studies and reports are retained per the required retention period and genuinely retrievable for comparison with prior studies, not archived in a way that makes practical retrieval difficult or unreliable.

1. Are prior studies genuinely, quickly retrievable for comparison, not a retrieval process that's cumbersome enough to discourage actually checking? — A comparison that's technically possible but practically avoided due to friction defeats the purpose.
2. Is the retention period actually met and verifiable, not assumed from a general archiving practice? — Verified against actual retrieval of an older study, not just a stated retention policy.
3. Is there a documented backup or redundancy process protecting against data loss? — A single point of failure in image storage is a specific, serious risk.

STANDARD 14

Oncology & Cancer Care

14.1 Cytotoxic Drug Handling Follows a Verified Safe-Handling Standard

NON-NEGOTIABLE

Preparation, administration, and disposal of cytotoxic and other hazardous drugs follows a defined, verified safe-handling standard — appropriate personal protective equipment, engineering controls, and disposal procedures — not informal practice that varies by individual staff member, including on inpatient wards where chemotherapy may be administered outside the dedicated infusion unit.

1. Is appropriate personal protective equipment used consistently for every stage of handling, including by inpatient ward nursing staff, not only dedicated infusion unit staff? — Consistent use at every stage and location, not only in the specialized infusion setting.
2. Are hazardous drugs prepared and stored using the required engineering controls, not standard pharmacy equipment? — Specific, required controls, not general pharmacy practice assumed to be sufficient.
3. Is hazardous waste disposed of through a defined, compliant pathway on every inpatient unit where it's generated, not general medical waste? — A specific, separate disposal pathway matched to the actual risk, available wherever cytotoxic agents are actually used.

14.2 Chemotherapy Dose Is Verified by Independent Two-Person Check

NON-NEGOTIABLE

Every chemotherapy dose, drug, route, and infusion rate is independently verified by two qualified individuals before administration, each forming their own judgement separately — not a single check followed by a second signature, and applied identically on inpatient wards as in the dedicated oncology unit.

1. Does every chemotherapy dose undergo independent verification by two qualified individuals before administration, on every unit where it's given? — Two people, every dose, without exception for perceived routine cases or off-unit administration.
2. Does each person form their own separate judgement, not simply confirm the first person's check? — Genuine independence, not sequential confirmation of the same conclusion.

3. Does verification specifically cover drug, dose, route, and infusion rate together, not dose alone? — All four elements, since an error in any one carries real risk.

14.3 Neutropenic Fever Triggers an Immediate, Time-Bound Response

NON-NEGOTIABLE

A patient with suspected neutropenic fever receives first-dose antibiotics within a defined, short time target from presentation, with staff trained to recognize the urgency and a protocol that bypasses routine triage queuing — not treated as a standard fever presentation.

1. Is there a defined, specific time target for first-dose antibiotics from presentation, genuinely tracked against actual practice? — A specific, measured target, not a general sense that treatment happens "promptly."
2. Do staff recognize neutropenic fever as a time-critical emergency distinct from routine fever, bypassing standard queuing? — Delay from routine triage treatment is a specific, well-documented risk for this patient population.
3. Is there a documented instance of this protocol being used with actual time-to-antibiotic data recorded? — Evidence the protocol genuinely functions, not just exists on paper.

14.4 Extravasation Is Recognised and Managed Immediately

CORE

Staff administering vesicant or irritant chemotherapy agents are specifically trained to recognise early signs of extravasation, with a defined, immediate management protocol and appropriate antidotes genuinely available wherever these agents are administered, including inpatient wards.

1. Are staff specifically trained to recognise early signs of extravasation for the agents actually used here, including ward nursing staff? — Specific to the actual agents administered, not generic infusion complication awareness.
2. Is there a defined, immediate management protocol for suspected extravasation accessible on every unit? — A specific, known protocol, not improvisation in the moment, available wherever the agent might be given.
3. Are appropriate antidotes for the specific vesicant agents used genuinely available wherever administration occurs? — Immediately available and in date on the actual unit, not only in the dedicated oncology area.

14.5 Multidisciplinary Tumor Board Informs Treatment Planning

CORE

Complex or newly diagnosed cancer cases are genuinely reviewed by a multidisciplinary tumor board before the treatment plan is finalized, with documented board input actually shaping the plan, not a single treating physician's decision presented as though it were a team decision.

1. Does a genuine multidisciplinary tumor board meet regularly and actually review complex or new cases, not exist nominally without real case review? — A board that meets but doesn't substantively review actual cases provides no real value.
2. Is board input documented as having actually shaped the treatment plan, not just noted as having occurred? — A documented instance where discussion specifically changed the plan is a real test of genuine function.
3. Does the board genuinely include relevant specialties — surgery, oncology, radiology, pathology — not a single specialty consulting nominally with others? — Real multidisciplinary input, not one discipline dominating with token representation from others.

14.6 Palliative Care Integrated Alongside Active Treatment

STANDARD

Palliative care expertise is genuinely integrated early in the course of serious cancer diagnoses, alongside active treatment, not introduced only once active treatment has been exhausted — with symptom management and goals-of-care conversations happening throughout, not as a late, separate referral.

1. Is palliative care genuinely introduced early, alongside active treatment, not only after active treatment options are exhausted? — Early integration provides real symptom and quality-of-life benefit distinct from end-of-life care alone.
2. Are goals-of-care conversations happening at meaningful points throughout the course, not deferred to a single late conversation? — Ongoing, not a one-time discussion held only when options have narrowed.
3. Is palliative referral genuinely accessible and actually used, not a resource that exists on paper but is rarely accessed? — Verified against actual recent use, not only the existence of a palliative care service.

STANDARD 15

Psychiatry & Mental Health

15.1 Suicide Risk Screening and Continuous Observation for High-Risk Patients

NON-NEGOTIABLE

Every psychiatric admission undergoes suicide risk screening using a validated tool, with a patient identified as high-risk placed on a genuinely continuous, documented observation level — not a screening completed once at admission with no follow-through into the observation practice that should result.

1. Is screening performed using a validated tool, applied consistently to every admission, not left to clinical impression alone? — A structured tool catches risk more reliably than impression alone, particularly for a patient who may not spontaneously disclose risk.
2. Is a high-risk observation level genuinely continuous and documented at real intervals, not nominal with gaps in practice? — A documented observation level that isn't actually maintained in practice provides no real protection.
3. Is observation level reassessed as risk changes during the admission, not fixed at the initial screening? — Risk can genuinely change during an admission; a level set once at intake may no longer reflect current status.

15.2 Environmental Ligature Risk Is Identified and Mitigated

NON-NEGOTIABLE

The psychiatric unit's physical environment is systematically assessed for ligature and other self-harm risk points, with identified hazards genuinely mitigated through environmental design or removal — not a one-time assessment that's never revisited as fixtures and furnishings change.

1. Has a systematic, documented ligature risk assessment actually been performed for the unit, not assumed from general psychiatric unit design standards? — A specific, documented assessment of this unit's actual environment, not an assumption based on general design principles.
2. Are identified hazards genuinely mitigated, not noted but left unaddressed? — A hazard identified but not corrected provides no real protection.
3. Is the assessment repeated when the physical environment changes, not treated as a one-time exercise? — New furnishings or fixtures can introduce new hazards not present at the original assessment.

15.3 Restraint and Seclusion Used as Genuine Last Resort, With Strict Documentation

NON-NEGOTIABLE

Physical restraint or seclusion is used only after genuine, documented attempts at de-escalation have failed, for the minimum time necessary, with each episode individually justified, time-limited, and reviewed — not a default response to agitation or a measure extended past clinical necessity.

1. Is there documented evidence that de-escalation was genuinely attempted before restraint or seclusion, not restraint used as a first response? — Restraint as a last resort, with real evidence of what was tried first, not the default response to agitation.
2. Is every episode individually, specifically justified and time-limited, not a blanket order applied without case-specific review? — A blanket or open-ended restraint order is a specific, serious failure mode this criterion exists to prevent.
3. Is there a genuine, timely review process checking whether restraint remains necessary, not continued without active reassessment? — Ongoing restraint without active, timely reassessment can persist well past genuine clinical need.

15.4 Psychiatric Medication Management Follows a Defined Interaction and Monitoring Protocol

CORE

Psychiatric medications, including those with significant interaction risk or requiring specific monitoring, are managed through a defined protocol covering interaction screening and required laboratory or clinical monitoring — not prescribed and administered without this structured safeguard.

1. Is interaction screening actually performed for every new psychiatric medication order, not assumed from the prescriber's general knowledge alone? — A systematic check, not reliance on an individual prescriber's memory for every known interaction.
2. Is required monitoring, such as specific lab tests for certain medications, genuinely scheduled and tracked, not left to chance? — Specific, required monitoring actually completed on schedule, not assumed to happen.
3. Is there a documented process for what happens when monitoring reveals an abnormal result? — Detection without a genuine clinical response provides limited protective value.

15.5 Staff Are Trained and Drilled in De-escalation, Not Only Briefed

CORE

Staff working on the psychiatric unit are trained and practically drilled in de-escalation technique, not only given a written policy to read, with training refreshed on a defined schedule, not completed once at hiring.

1. Has de-escalation training genuinely included practical drilling, not only a written policy or lecture-style session? — Practical, scenario-based training functions differently under real stress than a document only read.
2. Is training refreshed on a defined schedule, not completed once at hiring and never revisited? — Skills can fade without periodic reinforcement, particularly for a skill used infrequently by some staff.
3. Can staff describe their actual de-escalation approach confidently when asked, not struggle to articulate a concrete technique? — Confident, concrete description suggests the training genuinely embedded, not just technically completed.

15.6 Discharge Safety Planning With Follow-Up Care Genuinely Arranged

STANDARD

Before discharge, every psychiatric patient has a documented safety plan and a genuinely arranged, confirmed follow-up appointment — not a verbal recommendation to "follow up with your provider" with no actual appointment secured, given the specific, well-documented elevated risk in the period immediately following psychiatric discharge.

1. Does every discharge include a documented, individualized safety plan, not a generic handout given regardless of the patient's specific situation? — A genuinely individualized plan, not a standard form applied identically to every patient.
2. Is follow-up care genuinely arranged and confirmed before discharge, not a verbal suggestion with no actual appointment secured? — A confirmed appointment, not a recommendation the patient must arrange themselves during a known high-risk period.
3. Is there a documented process for following up if the patient misses their first post-discharge appointment? — A specific, active process for re-engagement during the known highest-risk window, not simply noting the missed appointment.

STANDARD 16

Academic Medical Center — Teaching & Research Governance

16.1 Resident and Trainee Supervision With Verified, Graduated Autonomy

NON-NEGOTIABLE

Each resident or trainee's current scope of independent practice is explicitly defined and documented, matched to their verified competency progression, with supervising physician involvement genuinely available at the level that scope requires — not assumed from training year or general program level alone.

1. Is each trainee's current scope of independent practice explicitly documented, not inferred from training year alone? — A specific, verified scope, not an assumption that a given training year implies a given level of independence.
2. Is supervising physician availability genuinely matched to the trainee's actual current scope, not a generic on-call arrangement? — Real, appropriate availability for the specific procedure or decision a trainee is performing, not a general backup presence.
3. Is scope of practice reassessed and updated as competency genuinely progresses, not fixed at program entry? — A trainee's verified competency can change meaningfully during training; scope should track actual demonstrated ability.

16.2 Patients Are Genuinely Informed of Trainee Involvement in Their Care

CORE

Patients are clearly, genuinely informed before or at admission that a teaching hospital's care model involves residents and trainees, with a real opportunity to ask questions about who is involved in their care — not a line buried in general admission paperwork that provides no genuine understanding.

1. Is trainee involvement disclosed clearly and specifically, not buried in general admission paperwork a patient is unlikely to genuinely read or absorb? — Clear, specific disclosure the patient actually registers, not a clause among many in a signed form.
2. Does the patient have a genuine, practical opportunity to ask who specifically is involved in their care? — A real opportunity to ask, not merely a theoretical right buried in policy.

3. Is the attending physician of record, distinct from any trainee, clearly identified to the patient? — The patient should know who holds ultimate responsibility for their care, separate from any trainee involved.

16.3 Research Activity Operates Under Independent Ethics Review Before Enrollment

NON-NEGOTIABLE

No patient is enrolled in a research study until that study has received approval from an independent ethics review board (IRB or equivalent), with the approval current and the enrolled patient's participation genuinely falling within the approved protocol — not research activity proceeding ahead of, or outside the scope of, that approval.

1. Is independent ethics board approval genuinely obtained and current before any patient enrollment, not assumed pending or informally proceeding? — Approval that's actually in place, not an application submitted with enrollment proceeding regardless.
2. Is the ethics board genuinely independent of the research team being reviewed, not effectively self-reviewing? — Real independence from the team whose research is under review, not a board with significant overlap or conflict.
3. Does each enrolled patient's actual participation genuinely fall within the approved protocol's scope? — A protocol deviation, even well-intentioned, falls outside the specific approval granted.

16.4 Clinical Care and Research Participation Are Clearly Separated in Consent

CORE

A patient genuinely understands which elements of their care are standard clinical treatment and which are research participation, with declining research participation never affecting the standard care they receive — not a blurred consent process that leaves a patient unclear what they're actually agreeing to.

1. Does informed consent genuinely distinguish standard clinical care from research participation, not present them as a single blended decision? — Genuine clarity about which parts are standard treatment versus which are research, not a combined consent that obscures the distinction.
2. Is it genuinely, explicitly clear to the patient that declining research participation will not affect the standard care they receive? — A patient should never feel their standard treatment is contingent on research participation.
3. Can a patient who initially consented genuinely withdraw from research participation at any point, with that withdrawal actually honored? — Genuine ongoing voluntariness, not a one-time consent treated as irrevocable.

16.5 Conflicts of Interest Between Research and Clinical Care Are Disclosed and Managed

CORE

A clinician's financial or other significant interest connected to a research study is disclosed through a defined process and genuinely managed — such as separating the clinician's research role from their direct clinical decision-making for enrolled patients — not left undisclosed or disclosed without any real management action following.

1. Is there a defined, actually-used process for a clinician to disclose a financial or other significant interest connected to a research study? — A real, functioning disclosure process, not a policy that exists on paper but isn't actually used.
2. Once disclosed, is the conflict genuinely managed through a concrete action, not merely logged with no follow-through? — Disclosure alone provides limited protective value without a genuine management step following it.
3. Is disclosure reviewed and refreshed periodically, not captured once and never revisited as circumstances change? — A conflict of interest can emerge or change after the original disclosure point.

16.6 Teaching Faculty Maintain Verified, Current Clinical Competency

STANDARD

Faculty teaching clinical skills maintain active, verified clinical competency in the skill being taught, confirmed through a defined process — not a teaching role assumed to carry current clinical competency simply from past experience or academic seniority.

1. Is current clinical competency, not past experience alone, genuinely verified for faculty teaching a given clinical skill? — Current, active competency verified through a real process, not assumed from years of past experience or academic rank.
2. Is competency verification repeated on a defined schedule, not confirmed once at initial faculty appointment? — Clinical competency in a given skill can change over time; a one-time check at appointment doesn't reflect current status.
3. Is there a defined process for addressing an identified competency gap in a teaching faculty member? — Identifying a gap without a genuine response process provides limited protective value.

STANDARD 17

Enterprise & Multi-Site Governance

17.1 Governance Structure Defines Authority Between Central and Site-Level Leadership

NON-NEGOTIABLE

For an organization operating multiple sites, explicit, documented governance defines which decisions belong to central/corporate leadership and which belong to site-level leadership, with no genuine ambiguity about who holds authority for a given decision — not an informal or assumed division that leaves real gaps when a decision actually needs to be made.

1. Is the division of authority between central and site-level leadership explicitly documented, not assumed or informal? — A written, specific division, not an unwritten understanding that can be interpreted differently by different people.
2. Can site leadership clearly identify who holds authority for a specific type of decision when asked? — A genuine test of whether the documented structure actually translates into practical clarity for the people who need it.
3. Is there a defined escalation path when a decision's ownership is genuinely unclear? — Even a well-documented structure can encounter an edge case; a defined path for resolving ambiguity matters.

17.2 Incident Learning Is Genuinely Shared Across Sites, Not Siloed

CORE

A serious incident identified at one site triggers a genuine review and dissemination process reaching every other site under the same governance structure, with lessons learned actually reaching relevant staff elsewhere in the network — not confined to the originating site as though it carries no relevance to the rest of the organization.

1. Is there a defined process for a serious incident at one site to genuinely reach other sites in the network? — A real, functioning cross-site process, not an assumption that lessons will somehow travel informally.
2. Do staff at other sites actually receive and register relevant incident learning, not merely have it technically distributed? — Genuine receipt and understanding, not just an email sent with no confirmation it was read or absorbed.
3. Does a pattern across multiple sites' incidents get identified and addressed at the network level? — A pattern invisible at any single site may only become visible when incidents are genuinely aggregated across the network.

17.3 Clinical Policy Is Standardized Across Sites, With Any Local Variation Explicitly Justified

CORE

Core clinical policies are standardized across every site in the network, with any permitted local variation explicitly documented and specifically justified — not silent, unexplained drift between sites that leaves patients receiving genuinely different standards of care depending on which site they visit.

1. Are core clinical policies genuinely standardized across sites, not left to independently drift at each location? — A shared baseline, not each site quietly developing its own version over time.
2. Is any permitted local variation explicitly documented and specifically justified, not simply tolerated without explanation? — A genuine, documented reason for variation, not an unexplained gap between what's written and what's actually practiced at a given site.
3. Is there a periodic process for checking that sites genuinely still follow the standardized policy, not assumed to remain aligned indefinitely? — Standardization can erode over time without active checking.

17.4 Credentialing and Privileging Are Centrally Verified and Consistently Recognized

NON-NEGOTIABLE

A clinician's credentials and clinical privileges are verified through a single, central process and consistently recognized across every site where that clinician practices, with no site allowing a clinician to practice without their current credentials and privileges actually being confirmed for that specific site.

1. Is credentialing verification genuinely centralized, not independently and inconsistently repeated or skipped at each site? — A single, reliable verification process, not a patchwork where sites verify differently or not at all.
2. Does every site confirm a clinician's current privileges before they practice there, not assume central verification covers every site automatically? — A specific, site-level confirmation step, even within a centralized system, closes a genuine potential gap.
3. Is there a reliable process for a privilege change or suspension at one site to genuinely propagate to all sites where that clinician practices? — A suspension that doesn't actually reach every site where the clinician practices creates a real, serious gap.

17.5 Central Resource and Staffing Decisions Are Evaluated for Site-Level Patient Safety Impact

CORE

A central decision affecting staffing, equipment, or resource allocation at a specific site is evaluated for its patient safety impact at that site before being finalized, with a documented process for that evaluation — not a purely network-level financial or operational decision made without genuine consideration of site-level patient safety consequences.

1. Is there a documented process for evaluating patient safety impact before a central resource decision affecting a specific site is finalized? — A genuine evaluation step, not a decision made purely on network-level financial or operational grounds.
2. Does site-level clinical leadership have a genuine voice in that evaluation, not merely informed after the decision is already made? — Real input before the decision, not notification after the fact.
3. Is there a mechanism for a site to flag a safety concern about a central resource decision and have it genuinely reconsidered? — A real, functioning escalation path, not a theoretical right with no actual avenue for reconsideration.

17.6 Site-Level Quality Data Is Genuinely Reviewed by Central Governance

STANDARD

Quality and safety metrics reported upward from each site are genuinely reviewed by central governance, with real follow-through action when a metric indicates a problem — not merely collected and filed as a reporting formality with no actual review or consequence.

1. Is site-level quality data genuinely reviewed by central governance, not simply collected and archived? — A real review process, not data flowing upward into a repository nobody actually examines.
2. Does a concerning metric from a specific site trigger a genuine follow-through action, not go unaddressed? — Detection without a real response provides limited protective value for patients at that site.
3. Can central governance identify, when asked, a specific recent example of acting on site-level quality data? — A concrete, recent example suggests genuine, ongoing practice rather than a theoretical process.

STANDARD 18

Sustainable Care

18.1 Environmental Impact Is Actually Reviewed at Strategic Level

STANDARD

Hospital leadership undertakes a genuine, strategic-level review of the facility's environmental impact and the sustainability of how it delivers care — not an assumption that environmental questions are someone else's concern or a problem for another department.

1. Has leadership conducted a genuine, documented review of the hospital's environmental impact, not left the question entirely unaddressed? — A real strategic review, not an assumption that this falls outside the hospital's own responsibility.
2. Does the review identify specific negative environmental impacts arising from the hospital's own activities? — Genuine, specific findings, not a generic statement of good intent with no actual content.
3. Does the review identify realistic ways the hospital could mitigate those impacts, even partially? — A real, actionable finding, not analysis that stops short of identifying what could actually change.

18.2 Staff and Patients Are Genuinely Informed of Sustainability Goals

STANDARD

The hospital's approach to environmentally sustainable care, and its goals in this area, are genuinely communicated to staff and patients — not confined to an internal policy document nobody outside senior management ever actually sees.

1. Is the hospital's sustainability approach and its goals genuinely communicated to staff, not confined to a policy document? — Real, visible communication, not information technically available but never actually shared.
2. Is the same information genuinely available to patients who want it, not withheld as an internal-only matter? — Genuine patient-facing transparency, not sustainability treated as purely an internal concern.
3. Can staff asked directly describe at least one specific sustainability goal the hospital is working toward? — Tests whether communication actually reached staff, not just whether it was technically issued.

18.3 Sustainability Progress Is Actually Reported to Governance

STANDARD

Progress against the hospital's environmental sustainability goals is genuinely reported to governance on a defined schedule — not tracked informally by whoever happens to care about it, with no real visibility at the level that sets institutional priorities.

1. Is progress against sustainability goals genuinely reported to governance on a real, defined schedule? — A real reporting cadence, not tracking that exists informally with no genuine visibility upward.
2. Does governance actually review this progress, not simply receive it as an unexamined item? — Genuine review, not a report circulated and filed without real engagement.
3. Is there a documented instance of a governance-level decision informed by sustainability progress data? — A real, concrete example, not a theoretical reporting line with no actual influence on decisions.

18.4 Procurement Genuinely Considers Responsible Stewardship of Resources

CORE

The hospital's procurement and supply decisions genuinely take environmental and social responsibility into account — reducing wasteful use of supplies, considering supplier environmental practices, and reviewing single-use equipment decisions against genuine patient and staff safety requirements — not sustainability treated as irrelevant to purchasing choices actually made.

1. Do procurement decisions genuinely take supplier environmental and social responsibility practices into account? — A real, documented consideration, not a purchasing process blind to anything beyond unit price.
2. Is wasteful use of supplies — packaging, single-use items, unnecessary ordering — genuinely reviewed and reduced where safely possible? — Real reduction efforts, not an assumption that current purchasing patterns are already optimal.
3. Where single-use equipment is reconsidered, is patient and staff safety — infection control, manufacturer guidance — genuinely protected throughout? — Safety never compromised for an environmental goal, verified, not assumed.

18.5 Energy Use Is Monitored, With a Genuine Move Toward Renewable Sources

STANDARD

The hospital genuinely monitors its use of electricity, gas, and other fuel sources, and takes real steps toward reducing reliance on fossil fuels where this is practically possible — not energy use left entirely unmeasured and unmanaged as a fixed, unexamined operating cost.

1. Is the hospital's use of electricity, gas, and other fuel sources genuinely monitored, not left entirely untracked? — Real, ongoing monitoring, not energy treated as an unexamined fixed cost.
2. Has the hospital taken any genuine, concrete step toward reducing fossil fuel reliance where practically possible? — A real, specific action, not a stated aspiration with no actual change behind it.
3. Where renewable energy options exist locally, has the hospital genuinely assessed their feasibility? — A real assessment, not an assumption that renewable transition is automatically impractical.

18.6 A Genuine Carbon Footprint Baseline Exists

STANDARD

The hospital has carried out a genuine assessment of its carbon footprint — even based on a minimal dataset such as energy use alone — to establish a real baseline for monitoring and reducing greenhouse gas emissions, not treating carbon impact as something too complex to ever actually measure.

1. Has the hospital carried out a genuine carbon footprint assessment, even a minimal one based on energy use? — A real, documented baseline, not an assumption that measurement is too complex to attempt.
2. Is this baseline genuinely used to monitor change over time, not calculated once and never revisited? — Real, ongoing tracking, not a one-time exercise with no follow-through.
3. Is there a realistic plan to extend the carbon footprint assessment as hospital resources allow? — A genuine forward plan, not a minimal baseline treated as a permanent ceiling on ambition.

18.7 The Hospital Genuinely Plans for Environmental and Climate Resilience

CORE

The hospital considers its resilience to major environmental, climate, or health emergencies that could disrupt service delivery — heatwaves, flooding, extreme storms, pandemic outbreaks — and plans a real range of actions in response, not assuming such disruptions are too remote to actually prepare for.

1. Has the hospital genuinely considered its resilience to major environmental or climate emergencies relevant to its location? — A real, specific assessment, not an assumption that such events are too remote to plan for.
2. Does a real plan exist for situational assessment and response that protects patient safety and continuity of care during such an emergency? — A genuine, actionable plan, not a general statement of intent with no real content.
3. Is the plan genuinely reviewed and updated, not written once and left unexamined as conditions change? — Real, periodic review, not a static document assumed to remain adequate indefinitely.

STANDARD 19

Digital Care and Artificial Intelligence Systems for Care

19.1 Digital Care Systems Follow a Genuine Assessment and Management Process

STANDARD

Before any digital care system — telehealth platform, remote monitoring tool, patient-facing app — is introduced, the hospital genuinely assesses its costs and benefits, manages its implementation, and continues to manage it afterward — not adopted because a vendor made a compelling pitch, with no real internal evaluation.

1. Is a genuine cost/benefit analysis conducted before any digital care system is implemented, not adopted on vendor assurance alone? — A real, documented evaluation, not a decision made purely on a sales pitch.
2. Is interoperability between the new system and existing hospital systems genuinely assessed, with risks from non-interoperability actually mitigated? — Real risk assessment, not an assumption that systems will simply work together.
3. Are potential unintended consequences of introducing the system genuinely considered before implementation, not discovered only afterward? — Real, proactive consideration, not a system deployed and its effects observed only in hindsight.

19.2 Digital Care Never Disadvantages a Patient Who Cannot Use It

CORE

A genuine process ensures that patients who cannot use digital devices, lack internet access, or are otherwise unable to engage with digital approaches are never disadvantaged by the hospital's use of digital care — not digital convenience for most patients purchased at the cost of real access for the patients least able to adapt.

1. Is there a genuine, defined alternative for patients who cannot or do not want to use a digital care approach? — A real, equally functional alternative, not a digital-only pathway with no real fallback.
2. Was the introduction of a new digital care service genuinely pre-tested with representatives of patients who might struggle to use it? — Real, prior testing with the affected group, not an assumption that accessibility will work out.
3. Is there evidence that a patient unable to use digital care actually received equivalent, undiminished service through the alternative route? — A real, demonstrated instance, not a theoretical alternative that has never actually been tested in practice.

19.3 Genuine Technical Expertise Supports Digital Care Systems

STANDARD

The hospital has genuine access to technical expertise — in-house, vendor-provided, or contracted — to support the effective use of its digital care systems, including testing and quality checks before full implementation, not digital systems left running with no real technical support behind them.

1. Does the hospital have genuine, accessible technical expertise — in-house or contracted — for its digital care systems? — Real, available support, not systems left to run unsupported once installed.
2. Were new testing and quality checks genuinely performed before full implementation of a digital care system? — A real pre-launch verification process, not a system deployed directly to patients untested.
3. When a digital system issue arises, is there a real, known route to technical support, not staff left to troubleshoot alone? — A genuine, known escalation path, not an assumption that someone will eventually sort it out.

19.4 AI Systems Are Introduced in Line With Law and Best-Practice Guidance

STANDARD

Any artificial intelligence system used to support diagnosis, triage, or care decisions is introduced and managed in accordance with applicable national or regional law and regulation, or in their absence, available best-practice guidance such as WHO's ethics and governance guidance for AI — not adopted with no reference to any external standard of responsible use.

1. Is any AI system in clinical use genuinely introduced in line with applicable law or regulation on AI, where this exists? — Real, verified compliance, not an assumption that general IT policy already covers AI-specific requirements.
2. Where no specific legislation exists, is the AI system's introduction genuinely informed by recognized best-practice guidance, such as WHO's AI ethics and governance guidance? — A real, referenced guidance source, not an ad hoc decision with no external grounding.
3. Can the hospital identify, when asked, the specific regulatory or guidance basis for how a given AI system is governed? — A real, specific answer, not a vague assurance that AI use is "handled appropriately."

19.5 AI Systems Are Genuinely Monitored for Unintended Consequences

STANDARD

The hospital genuinely monitors and evaluates its AI systems — auditing results for over-diagnosis or missed diagnosis, tracking patient complaints related to AI-assisted care, and checking for other unintended consequences — not deploying an AI tool and assuming it works as intended with no real, ongoing scrutiny.

1. Is the output of AI-assisted diagnosis or care decisions genuinely audited for over-diagnosis or missed diagnosis, not assumed reliable without checking? — Real, ongoing audit, not an assumption that AI accuracy requires no verification.
2. Are patient complaints or concerns related to AI-assisted care genuinely tracked and reviewed? — A real, specific tracking mechanism, not AI-related concerns absorbed into general feedback with no distinct visibility.
3. Is there a documented instance where monitoring identified an issue with an AI system's performance, and a genuine response followed? — A real, concrete example, not a monitoring process that has never actually caught anything in practice.

19.6 Staff Are Genuinely Consulted Before an AI System Is Introduced

STANDARD

Staff who will actually deliver care using a new AI system are genuinely consulted before it is introduced, to understand the practical implications and identify real training needs — not an AI tool rolled out to clinical staff with no engagement beyond a brief notification that it now exists.

1. Are staff who will actually use a new AI system genuinely consulted before its introduction, not informed only after the decision is finalized? — Real, prior consultation, not a rollout announcement to staff with no genuine input sought.
2. Does this consultation genuinely identify practical training needs, which are then actually addressed before go-live? — Real, identified needs matched by real, delivered training, not a consultation that produces no follow-through.
3. Can staff asked directly describe having been genuinely consulted about a recent AI system introduction? — Tests whether consultation actually reached and registered with staff, not just whether it technically occurred.

19.7 Accountability for AI-Assisted Care Is Explicitly Defined

STANDARD

The hospital has genuinely considered and documented accountability arrangements for care and treatment delivered with AI support — who is responsible when an AI-assisted decision is wrong — not leaving this as an unexamined question until the first time it actually matters.

1. Is clinical accountability for a decision made with AI support explicitly documented, not left genuinely ambiguous between clinician and system? — A real, clear answer, not an assumption that responsibility will sort itself out if something goes wrong.
2. Do clinicians using AI-supported tools genuinely understand their own accountability for the final care decision? — Real, demonstrated staff understanding, not a policy nobody using the tool has actually internalized.
3. Is there a defined process for reviewing accountability when an AI-assisted decision contributes to a safety incident? — A real, usable process, not a question left entirely open until an actual incident forces it.

19.8 Patients Are Genuinely Informed When Their Care Involves AI

STANDARD

A patient whose care involves an aspect delivered with AI system support is genuinely informed of this — not left to assume every decision was made by a human clinician alone, with disclosure treated as optional rather than a genuine, standard part of informed care.

1. Is a patient genuinely informed when an aspect of their care involves AI system support? — Real, standard disclosure, not an assumption that the patient will simply figure it out or doesn't need to know.
2. Is this disclosure genuinely understandable, not buried in technical language or a general consent form a patient never actually reads? — A real, plain-language explanation a patient could genuinely act on.
3. Can a patient asked directly confirm they were genuinely told AI was involved in an aspect of their care? — A real, concrete confirmation, not disclosure that exists in policy but never genuinely reaches the patient.

STANDARD 20

Supporting the Care Workforce

20.1 Every Member of the Workforce Is Genuinely Credentialed for Their Actual Role

CORE

Every member of the workforce — employed staff, independent practitioners with privileges, contracted care providers, and volunteers alike — has genuine assurance of the qualifications, licences, and scope of practice their role requires, and does not practise beyond that scope — not credentialing confined to directly-employed clinical staff while contracted and volunteer roles go unchecked.

1. Does genuine credential assurance extend to every category of workforce — employed, privileged, contracted, and volunteer — not employed clinical staff alone? — Real, consistent coverage across every workforce category, not a gap for contracted or volunteer roles.
2. Is each person's actual scope of practice genuinely verified against their real qualifications, not assumed appropriate for the role they've been assigned? — A specific, documented match, not an informal assumption that the role and the person's qualifications align.
3. Is there a real, defined process if someone is found practising outside their verified scope? — A genuine corrective process, not a gap identified with no actual response.

20.2 Ongoing Competency Is Genuinely, Regularly Evaluated

CORE

The continued competency and ongoing performance of every workforce member is genuinely, regularly evaluated against their actual job description and scope of practice — not competency assumed to remain current indefinitely once initial credentialing is complete.

1. Is ongoing competency genuinely evaluated on a real, defined schedule, not assumed to persist from initial hiring? — A real, periodic evaluation, not a one-time check treated as permanently sufficient.
2. Does this evaluation genuinely cover the person's actual current job description and scope, not a generic check unrelated to their real duties? — A specific, role-relevant evaluation, not a generic form applied uniformly regardless of actual role.
3. When an evaluation identifies a genuine performance gap, is there a real, defined response? — A genuine corrective process, not a gap noted with no actual follow-through.

20.3 Staff Have Genuine Access to Ongoing Education and Skill Development

STANDARD

Every workforce member has genuine access to ongoing education — formal courses and training sessions, whether internal or external — to maintain the performance their role requires and genuinely develop their skills further, not education treated as a one-time induction event with nothing meaningful offered afterward.

1. Does every workforce member have genuine, ongoing access to education beyond initial induction? — Real, continuing access, not training treated as a one-time event at hiring.
2. Are genuine opportunities for skill development and extension offered, not only the minimum required to maintain current performance? — Real development opportunities, not only remedial or compliance-driven training.
3. Can staff asked directly describe a genuine education opportunity they've taken in the past year? — A real, specific example, not a theoretical entitlement nobody actually uses.

20.4 Workforce Health and Safety Is Genuinely Protected

CORE

The hospital genuinely protects the health and safety of its workforce while they carry out their duties — required vaccinations, personal protective equipment, prevention of manual handling and needlestick injuries — not staff safety treated as secondary to patient safety rather than an equally real, equally protected concern.

1. Is personal protective equipment genuinely available and actually used by staff, not available in theory but inconsistently worn in practice? — Real, observed use, not equipment present but not actually worn.
2. Are genuine, specific measures in place to prevent manual handling and needlestick injuries, not a general safety policy with no concrete protective measures? — Real, specific protective measures, not a policy statement with no actual practice behind it.
3. Are required staff vaccinations genuinely tracked and current, not assumed complete with no real verification? — Real, verified tracking, not an assumption that staff vaccination status is current.

20.5 Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved

STANDARD

A genuine process exists for the investigation and resolution of workplace issues raised by workforce members — including whistleblowing concerns about organisational wrongdoing — with real protection from adverse treatment for those who raise them, not a grievance process that exists on paper with no real follow-through or genuine protection.

1. Is there a genuine, accessible process for staff to raise workplace issues, including whistleblowing concerns? — A real, known process, not a theoretical right with no practical, accessible channel.
2. Is there real, documented evidence that raised issues lead to genuine investigation and resolution? — Genuine follow-through, not a process that receives concerns without acting on them.
3. Are staff who raise concerns genuinely protected from adverse treatment, not merely told they are? — Real, demonstrated protection, not a stated non-retaliation policy with no actual confidence behind it.

20.6 Staff Are Genuinely Protected From Violence and Aggression

STANDARD

The hospital takes genuine, concrete steps to protect staff from violence and aggression — whether from patients, visitors, or other staff — ranging from verbal abuse and harassment through to physical assault, not workplace violence treated as an unavoidable, unaddressed feature of healthcare work.

1. Are genuine, specific measures in place to protect staff from violence and aggression, not a general policy with no concrete protective steps? — Real, specific measures — de-escalation training, panic alarms, security response — not policy alone.
2. Are incidents of violence or aggression toward staff genuinely tracked and reviewed, not treated as isolated, unrecorded events? — Real, systematic tracking, not incidents that go unrecorded and therefore unaddressed at a pattern level.
3. Can staff describe a real, specific instance where a protective measure genuinely worked as intended? — A real, concrete example, not protective measures that exist only in policy, untested in practice.

20.7 Workforce Feedback Is Genuinely Gathered and Acted On

STANDARD

The hospital has a genuine, systematic approach to gathering feedback from its workforce about their experience of working there, with real analysis of trends and a genuine, implemented response — not feedback collected occasionally with no real pattern of actual improvement resulting from it.

1. Is workforce feedback genuinely gathered on a systematic, recurring basis — satisfaction surveys, exit interviews, consultations? — Real, ongoing collection, not a single historical survey treated as sufficient indefinitely.
2. Is collected feedback genuinely analysed for trends, not simply filed without real examination? — A real, documented analysis process, not raw feedback collected and left unexamined.
3. Is there a documented instance where workforce feedback genuinely led to an implemented change? — A real, concrete example, not a feedback process that has never actually produced a visible change.

20.8 Sick Leave and Attrition Data Genuinely Inform Organisational Learning

STANDARD

The hospital genuinely monitors and analyses data on staff sick leave and the reasons people leave, using this data to inform real organisational learning and genuine changes in practice that support workforce wellbeing and retention — not attrition treated as an unexamined, unavoidable cost of doing business.

1. Is staff sick leave data genuinely monitored and analysed, not simply recorded with no real review? — Real, ongoing analysis, not data collected and left unexamined.
2. Are the genuine reasons staff leave the organisation actually captured, not assumed or left uninvestigated? — Real, specific exit data, not departures treated as self-explanatory with no real inquiry.
3. Is there a documented instance where this data genuinely informed a change supporting staff wellbeing or retention? — A real, concrete example, not data gathered with no demonstrated influence on actual practice.

20.9 Equality, Diversity and Inclusion Across the Workforce Are Genuinely Monitored

STANDARD

The organisation genuinely monitors and responds to real patterns of equity across recruitment, work allocation, scheduling, and promotion — not an assumption that fair treatment exists simply because no formal complaint has been raised.

1. Is workforce data on recruitment, work allocation, scheduling, and promotion genuinely monitored for patterns of inequity? — A real, documented monitoring process, not an assumption that fairness exists by default.
2. Where a genuine pattern is identified, is there a real, defined response? — A genuine corrective process, not data collected with no real follow-through.
3. Is there a real, documented instance of this monitoring genuinely informing a change in practice? — A concrete, real example.