

Ambulatory Clinic Standards — Full Guidance

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 127 criteria.

26 standards · 127 criteria · Version 4.0

Standard 1 — Access & Arrival

4 criteria · 3 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 1.1 — Findable Before Arrival
- 1.2 — A Genuinely Usable Entrance for Disabled Patients
- 1.3 — Approach and Grounds Safety
- 1.4 — Wayfinding Without Staff Dependence

1.1 Findable Before Arrival

NON-NEGOTIABLE

The clinic'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.

In plain terms: Anyone — a patient, a relative, an ambulance driver — can find your clinic's correct name, address, phone number and map location without help.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Patients search for a clinic the same way they search for anything: on their phone. If your Google Maps pin is 800 metres off, your listed phone number rings dead, or the address on your website is the old one, a patient in pain arrives late, a relative panics, an ambulance loses minutes. This is not a marketing issue. Every year facilities are found with the wrong address on official listings, and nobody noticed because staff never search for their own workplace. The cost of getting this wrong is measured in delayed arrivals, missed appointments, and for emergencies, in outcomes.

WHAT GOOD LOOKS LIKE

- Name, address, and phone number are correct and independently verifiable.
- A patient can cold call and reach the clinic within a minute.
- The mapped pin matches the real, physical entrance exactly.

COMMON FAILURE MODES

- An old address is still listed on letterhead, alongside a correct current one online.
- Listed number rings out with no voicemail, no way to confirm this is the right place.
- A map pin one street over from the real building, with no correction requested.

WORKED EXAMPLE

IN PRACTICE

A 12-room regional clinic in a mid-sized city, on a street renamed three years ago.

BEFORE

The Coordinator searched the clinic's name on Google. The map pin pointed to the old outpatient annex, 600 metres away. Two of the three phone numbers listed on the website were disconnected. A patient-review site listed opening hours from 2019. Staff had never noticed because they walk in the same door every day and never search for the address.

ACTION

The Coordinator (1) claimed the Google Business listing and corrected the pin, address, phone and hours; (2) checked the website, the Ministry of Health directory, and the two main local

directories and fixed each; (3) called each listed phone number from an outside line to confirm it rang and was answered; (4) added a quarterly check to the calendar.

AFTER

Searching the clinic name now returns one correct listing with a working phone. The Monitor tested it independently from a personal phone, called the number, and confirmed a human answered. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Search your clinic name on Google Maps from a personal phone — where does the pin land?
2. Call every phone number you list publicly, from an outside line.
3. Check your address on the Ministry directory and your own website — do they match?
4. Note every discrepancy in one list before fixing anything.

The most common mistake: Facilities check their own website and assume the map and directories say the same thing — they usually don't.

SELF-ASSESSMENT QUESTIONS

1. Is the clinic name, address, and phone number correct on your own website and any public listing? — *Not the address on file years ago — what a patient searching today would actually find.*

Evidence: Website screenshot, public listing

2. Does the phone number listed actually connect to your clinic when called? — *Tested directly, not assumed correct because it was correct when first published.*

Evidence: Call log or test record

3. If a map location is used, does the pin match the real entrance, not a nearby approximation? — *A pin one block off sends patients to the wrong door, or ambulances to the wrong street.*

Evidence: Map screenshot

4. Is the range of services the clinic actually provides published somewhere a prospective patient can find it before contacting the

clinic, and kept up to date? — *Genuinely current public information, not a service list last updated years ago or only available by asking.*

Evidence: Website services page, publication date

COMMON REASONS FOR A PARTIAL ANSWER

- **The website was never updated after a move.** — The clinical team changed but nobody told whoever manages the website — a common, low-cost, high-consequence gap.
- **The phone number is correct but nobody answers as "the clinic."** — Calls connect to a generic switchboard that cannot confirm this is the right place.
- **The map pin was set once, years ago, and never checked again.**

IMPLEMENTATION PLAN

When	What
Week 1	Search for your own clinic exactly as a patient would, across every platform patients actually use.
Week 2	Correct the address and phone number on your own website and any listing you control directly.
Week 3	Call your own listed number from an outside line and time how long it takes to confirm you've reached the right place.
Ongoing	Recheck all public listings every six months.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Public search test	Independently searches for the clinic exactly as a patient would — by name, address, phone — using only public information.
DOCUMENT	Address cross-check	Confirms the mapped or listed address matches what is physically found on arrival.
ASK	Cold-call directions test	Calls the listed number posing as a first-time patient asking for directions, and notes whether the answer is accurate without hesitation.

SUPERVISOR TIPS

- **Search cold, don't ask the clinic for directions first.** — The whole point is testing what a stranger finds.
- **Call from a number the clinic won't recognise.** — A number in the clinic's own contact list may get special handling a real patient wouldn't.

EVIDENCE BASE

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

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1.2 A Genuinely Usable Entrance for Disabled Patients

NON-NEGOTIABLE

At least one entrance is step-free or served by a compliant ramp, with a door wide enough for a wheelchair to pass through without difficulty and hardware operable with one hand. Where this does not yet exist, the clinic holds a specific, budgeted, dated plan to close the gap.

In plain terms: A wheelchair user can get through at least one door on their own — no step, wide enough, opens with one hand — or you have a dated, budgeted plan to make it so.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Disabled patients are the most frequent users of healthcare and the most often excluded from it by a single step at the door. A ramp that is too steep, a door too narrow for a wheelchair, a handle that requires two hands — each turns a clinic into a place the patient cannot enter without being carried. For a clinic, this is doubly important: there is no porter, and the receptionist cannot leave the desk. The standard

accepts that older buildings cannot be fixed overnight, but only if there is a real plan: a quote, a budget line, a date. 'We help them in' is not a plan.

WHAT GOOD LOOKS LIKE

- At least one entrance is genuinely step-free or ramped to a safe healthcare-grade gradient.
- The door is wide enough for a standard wheelchair to pass without assistance.
- Where access doesn't yet exist, a specific, funded, dated plan is in place and visibly being followed.

COMMON FAILURE MODES

- The only entrance has steps with no ramp alternative at all.
- A ramp exists but is too steep to be genuinely safe, effectively decorative.
- No specific plan exists — only a general acknowledgement that access "should be improved sometime."

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic in a converted ground-floor apartment with two steps at the entrance.

BEFORE

Wheelchair patients were lifted up the steps by whoever was available — sometimes the patient's relative, sometimes the receptionist. The door was 70 cm wide; standard wheelchairs are 65–70 cm. There was no plan and no budget. The clinic owner said 'we've never had a complaint.'

ACTION

The Coordinator got a quote for a compliant ramp (1:12 gradient) and widening the door to 90 cm with a lever handle. The owner approved a budget line with a completion date four months out. A portable ramp was bought immediately. The plan was written on one page and signed.

AFTER

The Monitor reviewed the signed plan, the quote, the budget line, and observed the portable ramp in use. The criterion is met on the plan; the Monitor will re-check at the date. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Measure your entrance door width. Under 85 cm fails.
2. Count steps at every public entrance. Any step without a ramp fails.
3. Get one quote for the cheapest compliant fix.
4. Write a one-page plan with cost, date, and owner — signed by the Director.

The most common mistake: Confusing 'we manage to get wheelchair users in' with access — being carried is not access.

SELF-ASSESSMENT QUESTIONS

1. Is there at least one step-free entrance, or a ramp meeting a genuine healthcare-grade gradient, not a makeshift board? — *A steep improvised ramp can be more dangerous than stairs — this means a real, safe gradient.*

Evidence: Photo of entrance and ramp

2. Can a standard wheelchair pass through the entrance door without the user needing help to squeeze through? — *A specific, measurable width, not a visual impression that it looks wide enough.*

Evidence: Door width measurement

3. Where full access doesn't yet exist, is there a specific, dated, budgeted plan to fix it — not a general intention to "look into it eventually"? — *A plan with a number and a date, the same standard applied throughout this whole framework.*

Evidence: Written access improvement plan

COMMON REASONS FOR A PARTIAL ANSWER

- **A ramp exists but was built to a residential, not healthcare-grade, gradient.** — A ramp steep enough for general use can still be unsafe for a wheelchair user managing it alone.
- **The main entrance is accessible but a secondary or side entrance patients sometimes use is not.** — Accessibility needs to

hold at whichever entrance a patient is actually directed to, not just the primary one.

- **A plan exists but has no specific budget or date attached to it.**

IMPLEMENTATION PLAN

When	What
Week 1	Measure your actual entrance — door width, ramp gradient if one exists — against the healthcare-specific guideline.
Week 2	If full access isn't achievable immediately, write a specific plan with a real budget figure and completion date.
Week 3	If a temporary workaround is needed in the meantime, make it genuinely safe, not just present.
Ongoing	Revisit the plan's progress against its own stated date.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Physical entrance check	Directly tests the entrance and ramp gradient, and attempts entry as a wheelchair user would.
DOCUMENT	Door width measurement	Measures the actual clear door width against the healthcare-specific guideline threshold.
DOCUMENT	Access plan review	Where full access doesn't exist, reviews the specific plan for a real budget and date, not a vague aspiration.

SUPERVISOR TIPS

- **Try to enter as a wheelchair user would, don't just look at the ramp.** — A ramp that looks adequate can still be unsafe to actually use alone.
- **Ask for the specific budget figure and date in the access plan, not a general description of intent.** — Specificity is what distinguishes a real plan from a good intention.

EVIDENCE BASE

[2] International Health Facility Guidelines. Part C — Access, Mobility and OH&S. Sydney: Health Facility Guidelines; and United Nations. Convention on the Rights of Persons with Disabilities. New York: UN; 2006. Article 9.

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1.3 Approach and Grounds Safety

NON-NEGOTIABLE

The immediate approach to the clinic — parking area, entryway, path from the street — is safe, clean, and well lit, not merely the building interior once a patient has already arrived.

In plain terms: The car park, path, and entrance are safe, clean, and lit — the clinic's responsibility starts at the street, not the door.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A patient who trips on broken paving in the car park has been injured at your clinic. A patient who cannot see the entrance at 6pm in winter goes home. A patient who has to cross a rubbish-strewn alley to reach you has already formed their opinion. The approach is where the patient is most vulnerable — often alone, often unwell, often in the dark — and it is the part of the premises clinics most often treat as someone else's problem. It is not. If the patient has to walk it to reach you, it is yours to make safe.

WHAT GOOD LOOKS LIKE

- The approach is free of trip hazards, well lit, and genuinely walkable.

COMMON FAILURE MODES

- Uneven paving or poor lighting on the approach

- The route stays consistently clear of obstruction.
- A specific person or role owns approach safety and maintenance.

has never been addressed.

- The entryway is regularly blocked by parked vehicles or stored equipment.
- Nobody can identify who is responsible for noticing or fixing a hazard on the approach.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic on the ground floor of a commercial building with a shared car park.

BEFORE

The car park had two potholes and no lighting. The path from the car park to the clinic entrance crossed a loading bay used by a neighbouring shop. There was no sign visible from the road. Evening patients had complained about feeling unsafe. The clinic considered the car park the landlord's responsibility.

ACTION

The Coordinator walked the approach at 7pm and documented every hazard with photographs. The landlord was asked in writing to fix the potholes and lighting; when they declined, the clinic paid for two lights and pothole repair itself. A painted pedestrian path was added around the loading bay. An illuminated sign was mounted at the road.

AFTER

The Monitor walked from the road to the entrance at dusk: lit, clear, signed, with a marked path. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk from the street to your door at your latest opening time. Photograph everything.
2. List every hazard: lighting, surface, obstruction, signage.

3. Ask the landlord in writing. If refused, fix it yourself — it is your patients.
4. Add the approach to your monthly safety walk.

The most common mistake: Treating the car park as the landlord's problem while your patients fall in it.

SELF-ASSESSMENT QUESTIONS

1. Is the walkway from the street or parking area to the entrance free of trip hazards and adequately lit? — *Checked directly underfoot, not assumed safe because it looks fine from a distance.*

Evidence: Photo of approach, day and evening if relevant

2. Is the approach kept clear of obstruction — parked vehicles, stored materials, snow or ice where relevant? — *A route that's sometimes blocked is not a reliably safe route.*

Evidence: N/A — tested directly

3. Is there a specific, assigned responsibility for keeping the approach safe, not a general hope someone will notice a hazard? — *Specific ownership, not diffuse responsibility that belongs to nobody in particular.*

Evidence: Role assignment record

COMMON REASONS FOR A PARTIAL ANSWER

- **The approach is well maintained during the day but poorly lit after dark.** — A hazard assessment done only in daylight can miss a genuine evening safety gap.
- **Maintenance happens reactively after a complaint, not on any regular schedule.** — Waiting for a complaint means at least one patient experienced the hazard first.
- **Responsibility is informally understood by long-term staff but not written down anywhere.**

IMPLEMENTATION PLAN

When	What
Week 1	Walk the approach yourself, including after dark if the clinic operates evening hours.
Week 2	Fix any immediate hazard found — lighting, uneven surface, obstruction.

When	What
Week 3	Assign specific, written responsibility for ongoing approach safety.
Ongoing	Recheck the approach on a fixed schedule, not only after a complaint.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Approach walk-through	Physically walks the entire approach from the street or parking area to the entrance, checking for hazards.
OBSERVE	Obstruction check	Checks whether the approach is currently clear, and asks how recently it was last checked.
ASK	Responsibility interview	Asks who is specifically responsible for approach safety and maintenance.

SUPERVISOR TIPS

- **Walk the approach yourself rather than asking staff to describe it.** — A route staff walk daily can become invisible to them even when a real hazard exists.
- **Ask specifically about evening conditions if the clinic has evening hours.** — Daytime safety and evening safety are genuinely different conditions.

EVIDENCE BASE

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

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1.4 Wayfinding Without Staff Dependence

CORE

Basic wayfinding allows someone with no prior knowledge of the clinic to locate reception and the relevant waiting area without stopping to ask for directions more than once.

In plain terms: Someone who has never been in your building can find reception, a toilet, and the main clinical areas by following signs — without having to ask more than once.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

Staff stop seeing signs after their first week. That is why clinics are so often confusing to patients while seeming perfectly clear to the people who work there. The people who suffer most are the ones least able to ask: someone in pain, someone who does not speak the local language well, an elderly relative, a frightened parent. Each of them ends up either wandering or stopping staff — and staff stopped for directions are staff not doing their job. Good wayfinding is not decoration; it reduces missed appointments, late arrivals to procedures, and the low-level stress that makes everything else harder.

WHAT GOOD LOOKS LIKE

- A first-time visitor reaches reception without confusion.
- Signage is current, clear, and consistently used.
- Where the clinic is small enough that formal signage is genuinely unnecessary, this is a real fit, not a gap being excused.

COMMON FAILURE MODES

- Visitors regularly get lost or need multiple directions from staff.
- Signage is outdated, inconsistent, or missing at key decision points.
- A larger, layout-complex clinic has no signage at all, relying entirely on staff to guide every visitor.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic across three connected buildings with a mix of old and new signage.

BEFORE

The Coordinator asked a friend who had never visited to find the outpatient X-ray department from the front door. She asked for directions four times. Signs used department names that had changed. One corridor had a sign pointing left to 'Radiology' and another pointing right to 'X-Ray' — the same place. Toilet signs were absent from two of three waiting areas.

ACTION

The Coordinator mapped every decision point — every place a visitor must choose a direction — and listed what sign was needed there. They standardised names (one name per department, everywhere), removed contradictory signs, and added toilet signs at every waiting area. They tested again with a second first-time visitor.

AFTER

The second visitor found X-ray with one question. The Monitor repeated the test independently, found reception, a toilet, and two clinical areas from the entrance without asking. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask someone who has never visited to find reception, a toilet, and one clinical department — count the questions.
2. Walk every corridor and list every place a visitor has to choose a direction.
3. Check whether each department has exactly one name on every sign.
4. Fix the worst decision point first.

The most common mistake: Asking staff whether the signage is clear — staff know the building and cannot see it as a stranger does.

SELF-ASSESSMENT QUESTIONS

1. Can a first-time visitor find reception without asking for directions more than once? — *Tested directly by someone unfamiliar with the layout, not assumed from staff familiarity.*

Evidence: N/A — tested directly

2. Is signage clear and consistent, not relying on informal or outdated labels? — *Signage that matches how staff actually refer to a space, not a leftover label from a previous use.*

Evidence: Photo of signage

3. For a very small clinic where the whole space is visible from the entrance, is a lighter approach genuinely sufficient? — *A one-room clinic may not need formal signage at all — this asks whether that's a genuine fit, not an excuse.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Signage exists for the main path but not for less obvious secondary routes.** — The most complex parts of a layout are exactly where clear guidance matters most.
- **Signage was accurate when installed but hasn't been updated as rooms changed use.** — A label pointing to a room's old purpose actively misleads rather than helps.
- **Reception staff have become so used to giving directions that the underlying confusion is normalised rather than fixed.**

IMPLEMENTATION PLAN

When	What
Week 1	Ask someone unfamiliar with the clinic to find reception unassisted and note where they hesitate.
Week 2	Add or correct signage at the specific points of confusion identified.
Week 3	Confirm with reception staff whether directional questions have genuinely decreased.
Ongoing	Recheck signage accuracy whenever room use changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	First-time visitor test	Approaches as a first-time visitor would, checking whether reception can be found without repeated direction-asking.
OBSERVE	Signage consistency check	Checks that signage is current, consistent, and matches actual space use.
ASK	Reception burden interview	Asks reception staff how often they are asked basic directional questions during a typical day.

SUPERVISOR TIPS

- **Use a genuinely unfamiliar person for the test, not clinic staff.**
— Staff familiarity makes it impossible to judge wayfinding as a real first-time visitor would experience it.
- **Ask reception staff directly how often they field basic directional questions.** — A high frequency is itself evidence of a wayfinding gap, regardless of how staff have adapted to it.

EVIDENCE BASE

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

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← Ambulatory Clinic
Standards — all standards

Self-assess against these
criteria →

Standard 2 — Reception &
Information →

ASF STANDARDS · AMBULATORY CLINIC · STANDARD 2

Standard 2 — Reception & Information

5 criteria · 2 non-negotiable · 3 core · Version 3.0

CRITERIA IN THIS STANDARD

- 2.1 — Patients Know Their Rights
- 2.2 — Pricing Is Disclosed Before Care Begins
- 2.3 — Reception Desk Accessibility
- 2.4 — Health Information Is Genuinely Understandable, Not Just Provided
- 2.5 — Waiting and Queue Time Is Actively Managed

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.

In plain terms: Patients can see their rights displayed and can tell you, in their own words, what those rights are — it is not a poster nobody reads.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A patient who knows they have the right to ask questions, refuse treatment, or see their own records behaves differently: they ask, they participate, they catch errors. A patient who does not know is passive, and passive patients are less safe. Most clinics have a rights charter somewhere — in a policy binder, on a faded poster behind the reception desk. That is not the same as patients knowing their rights. The test is simple: stop a patient in the corridor and ask them to name one right they have here. If they cannot, the charter has failed, however well-written it is.

WHAT GOOD LOOKS LIKE

- The charter is visibly posted in the waiting area, in the languages patients speak.
- A patient asked directly can describe at least one specific right.
- Staff can point to where the charter is displayed without hesitation.

COMMON FAILURE MODES

- The charter exists only in an office, never seen by patients.
- Patients asked directly have no idea they have any specific rights.
- The charter exists in only one language in a multilingual patient population.

WORKED EXAMPLE

IN PRACTICE

A 90-bed city clinic with a patient rights charter written in 2015.

BEFORE

The charter was on an A4 sheet in a frame behind reception, in dense legal language. The Coordinator asked five patients on the treatment area what rights they had. Three said 'I don't know.' One said 'to be treated well.' One said 'to complain, I think.' Nurses had never been asked

	to discuss rights with patients and did not know the charter's contents either.
ACTION	The Coordinator rewrote the charter as six plain sentences in the local language, printed it large in every waiting area and treatment area, and put a one-line summary on the registration form that the nurse reads aloud. A 10-minute session was added to nursing handover once, and the charter was added to the patient information booklet.
AFTER	Four weeks later, the Monitor asked six patients at random. All six named at least two rights in their own words. Two mentioned the nurse had explained them at registration. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five patients today: 'What rights do you have as a patient here?' Write down what they say.
2. Find your charter. Read it aloud. If it takes more than 60 seconds, it is too long.
3. Rewrite it as five or six short sentences in the language patients speak.
4. Put it where patients sit and wait, at eye level, in large type.

The most common mistake: Having a legally complete charter that patients cannot read and staff never mention.

SELF-ASSESSMENT QUESTIONS

1. Is a patient rights charter visibly displayed in the waiting area? — *Posted where a patient waiting would actually see it, not filed in an office.*
Evidence: Photo of displayed charter
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.*
Evidence: Charter text, all language versions
3. Can a patient asked directly describe at least one of their rights in their own words? — *Tests whether the charter reached them, not*

whether it exists.

Evidence: N/A — tested directly

4. Does the charter explicitly state the patient's right to refuse treatment, with staff able to describe what happens when a patient exercises it? — *A genuine, honoured right, not a line in a document with no defined practice behind it.*

Evidence: Charter text, staff interview

5. Is there a real, accessible process for a patient to request spiritual or religious care or accommodation of cultural practice? — *A specific, usable process a patient can actually invoke, not only general staff sensitivity.*

Evidence: Accommodation request process

COMMON REASONS FOR A PARTIAL ANSWER

- **The charter is displayed but only in the majority language.** — A meaningful minority of patients may be functionally unable to read it.
- **The charter is posted but written in legal or clinical language.** — Technically available and practically accessible are different things.
- **Staff know the charter exists but have never actively explained it to a patient.**

IMPLEMENTATION PLAN

When	What
Week 1	Check current display location and language coverage.
Week 2	Rewrite in plain language if the current version is legal or clinical in tone.
Week 3	Translate into the languages your patients actually speak.
Ongoing	Brief reception staff to actively reference the charter.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Display check	Checks whether the charter is genuinely visible in the waiting area.

Method	What	Detail
ASK	Patient awareness test	Asks a patient, unprompted, whether they know they have specific rights here.
DOCUMENT	Language coverage check	Reviews which languages the charter covers against the patient population.

SUPERVISOR TIPS

- **Ask a patient directly, don't rely on staff description.** — Staff describing the policy and a patient's actual awareness are different things.
- **Check language coverage against the actual patient population.** — A single-language charter can look complete while failing a meaningful share of patients.

EVIDENCE BASE

[5] World Health Organization. Framework on integrated, people-centred health services. Geneva: WHO; 2016.

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2.2 Pricing Is Disclosed Before Care Begins

CORE

Patients receive clear, written information about the cost of a service before treatment begins, in a form they can keep, not only on the final invoice.

In plain terms: Before treatment starts, patients get clear written information about what it will cost — in a form they can understand and take away.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A patient who does not know the price cannot consent to it. Surprise bills after treatment are one of the leading causes of complaints, unpaid invoices, and lost trust in clinics everywhere. They also create a quiet injustice: the patient who cannot afford the bill often finds out only after the procedure. Clear pricing before care lets patients make real choices, plan, and — where necessary — ask for help or an alternative. It also protects the clinic: a documented estimate given before treatment is the strongest defence against a later dispute. 'The price list is at the cashier' is not disclosure; it is a place the patient did not go.

WHAT GOOD LOOKS LIKE

- Pricing is disclosed in writing before treatment, consistently.
- Patients can describe roughly what they were told a service would cost.
- Estimates are honest and close to final costs, with changes explained.

COMMON FAILURE MODES

- Patients learn the cost only when the invoice arrives.
- Pricing is mentioned verbally once with no written record.
- Patients report being surprised by charges never mentioned beforehand.

WORKED EXAMPLE

IN PRACTICE

A private 80-bed clinic with fixed tariffs but no standard practice of giving them to patients in advance.

BEFORE

Prices existed in a spreadsheet at the cashier's desk. Patients were told costs verbally, sometimes, by whoever admitted them. The Coordinator reviewed the last 20 complaints: 8 were about unexpected charges. Patients said they were told one figure and billed another because of items not mentioned — dressings, lab tests, a second night.

ACTION

The Coordinator built a one-page estimate template listing the procedure, expected stay, common extras, and a total range. Admission staff were required to complete it, explain it, and

give the patient a copy before any elective registration. For emergencies, the estimate was given as soon as the patient was stable. A signature line confirmed the patient had received it.

AFTER

The Monitor reviewed 15 recent registration files: all had a signed estimate. Interviewed three patients who could describe roughly what they expected to pay. Complaints about billing dropped to one in the following quarter. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull your last 20 complaints — how many are about cost surprises?
2. Ask three recent patients what they expected to pay and what they were charged.
3. Draft a one-page estimate sheet: procedure, stay, likely extras, total range.
4. Make it a required step at registration with a copy to the patient.

The most common mistake: Having a price list available on request and calling that disclosure — patients rarely know to ask, and rarely ask when they are unwell.

SELF-ASSESSMENT QUESTIONS

1. Is pricing disclosed before treatment begins, not only on the final invoice? — *Disclosure after the fact doesn't allow an informed decision.*

Evidence: Pricing disclosure sample

2. Is pricing given in writing the patient can keep, not only spoken once? — *A spoken mention easily forgotten is not the same as something to refer back to.*

Evidence: Written estimate

3. Can a patient describe roughly what they were told a service would cost? — *Tests whether the disclosure actually registered.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Pricing is disclosed for the main procedure but not consistently for add-ons.** — Ancillary charges often accumulate without the same disclosure discipline.
- **A written estimate exists but in language patients find hard to use.** — Technically available and practically useful are different things.
- **Disclosure happens reliably for scheduled visits but less for same-day walk-ins.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent bills against whether pricing was disclosed beforehand.
Week 2	Build a simple written pricing estimate template.
Week 3	Brief reception staff to provide it consistently, including for walk-ins.
Ongoing	Spot-check patient recall of pricing periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Disclosure timing review	Reviews records for evidence pricing was disclosed before treatment, not only invoiced after.
OBSERVE	Written format check	Checks pricing is provided in a retainable written form.
ASK	Patient recall check	Asks a recent patient what they recall being told about cost beforehand.

SUPERVISOR TIPS

- **Ask a patient what they were told, not what the policy says.** — The gap between policy and lived experience is exactly what this checks.
- **Check same-day walk-in visits specifically.** — Disclosure discipline most commonly erodes under time pressure.

EVIDENCE BASE

[6] World Health Organization. Tracking universal health coverage: financial protection global monitoring report. Geneva: WHO; 2021.

This course teaches practical implementation of this standard. Free to enroll. ASF certificate on completion.

2.3 Reception Desk Accessibility

NON-NEGOTIABLE

At least one reception point is at a height a wheelchair user can approach and communicate with the receptionist at eye level.

In plain terms: At least one reception desk is low enough that a wheelchair user can talk to the receptionist face to face, not looking up at a counter.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A high counter forces a wheelchair user to crane up treatment area, speak to a wall, or rely on someone else to lean over. It is a small physical thing that sends a large message: you were not expected here. It also creates practical failures — the receptionist cannot see documents the patient is holding, cannot hear clearly, and conversations that should be private are conducted at a shout. This is one of the cheapest accessibility fixes in the whole standard — a lowered section of counter, or a side desk — and one of the most often missed because nobody who works at reception uses a wheelchair.

WHAT GOOD LOOKS LIKE

- A wheelchair-height reception point exists and is kept clear.
- A wheelchair user can interact at genuine eye level.

COMMON FAILURE MODES

- The entire desk is standard height with no accessible alternative.
- A lower section exists but is covered with files or equipment.

- Staff actively use the accessible point without prompting.

- Staff are unaware an accessible point exists.

WORKED EXAMPLE

IN PRACTICE

A 8-room clinic whose main reception is a single 1.1-metre counter.

BEFORE

The Coordinator borrowed a wheelchair and approached reception. Her eye level was below the counter top. The receptionist stood and leaned over to see her. Documents had to be passed up. A patient in a wheelchair was observed giving their date of birth loudly enough for the whole waiting room to hear because the receptionist could not hear at that angle.

ACTION

Facilities cut a 90-cm section at one end of the counter and lowered it to 75 cm with knee clearance underneath, at a cost of one day's carpentry. A small sign marked it. Reception staff were told to invite wheelchair users to that end.

AFTER

The Monitor approached in a wheelchair, was invited to the lowered section, and completed registration at eye level with the receptionist. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Sit in a wheelchair or a low chair and approach your reception desk — can you see and be seen?
2. Measure the counter height; anything over 85 cm fails for most wheelchair users.
3. Get a quote to lower one section or add a side desk — usually a one-day job.
4. Tell reception staff to use it.

The most common mistake: Assuming a receptionist who stands up and leans over solves the problem — it does not, and it is not private.

SELF-ASSESSMENT QUESTIONS

1. Is at least one reception point at a height a wheelchair user can comfortably use? — *At least one section genuinely usable, not the whole desk.*

Evidence: Photo of reception desk height

2. Can a wheelchair user communicate with the receptionist at eye level? — *Genuine eye-level interaction, not shouting up over a counter edge.*

Evidence: N/A — tested directly

3. Is the lower section kept clear, not blocked by files or equipment? — *A lower section that's permanently cluttered doesn't meet this in practice.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A lower section was built but has become a storage spot for overflow items.** — Good design intentions don't guarantee the space stays usable in daily practice.
- **The accessible point exists but is positioned away from the main queue.** — Physical accessibility without dignified positioning only partly closes the gap.
- **New staff aren't briefed on the accessible point during induction.**

IMPLEMENTATION PLAN

When	What
Week 1	Check current desk height against accessible guidelines.
Week 2	Identify the lowest-cost way to add an accessible section if none exists.
Week 3	Clear and designate the section, briefing all staff.
Ongoing	Include the accessible point in routine walk-throughs.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Desk height check	Physically checks reception desk height against accessible guidelines.

Method	What	Detail
OBSERVE	Clear access test	Checks the lower section is genuinely clear and usable.
ASK	Staff awareness interview	Asks staff whether they're aware of and use the accessible section.

SUPERVISOR TIPS

- **Physically check the height yourself.** — A technically accessible but cluttered section doesn't function as intended.
- **Ask a staff member to demonstrate, not just describe.** — Genuine use versus theoretical awareness shows in how confidently they point to it.

EVIDENCE BASE

[7] United Nations. Convention on the Rights of Persons with Disabilities. New York: UN; 2006. Article 9.

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2.4 Health Information Is Genuinely Understandable, Not Just Provided

CORE

Health information given to patients is delivered in plain language and verified as actually understood, not handed over in clinical terminology and assumed to have registered.

In plain terms: Patients actually understand what you have told them about their condition and next steps — you check, rather than assume.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Doctors and nurses explain things all day. Patients forget most of it within an hour, and misunderstand a good share of the rest — especially when frightened, in pain, or hearing bad news. A patient who does not understand takes the wrong dose, misses the follow-up, or does not return when symptoms worsen. The fix is not to explain more; it is to check. 'Teach-back' — asking the patient to say in their own words what they will do — takes 30 seconds and catches the misunderstanding before it does harm. Information that is provided but not understood is not information; it is a liability.

WHAT GOOD LOOKS LIKE

- Information is consistently delivered in genuine plain language.
- Patient understanding is actively verified.
- Materials are available in the languages patients actually need.

COMMON FAILURE MODES

- Information relies on unexplained clinical terminology.
- Understanding is assumed from a nod.
- Materials exist only in the default language regardless of patient need.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic where doctors explain diagnoses at the bedside during rounds.

BEFORE

The Coordinator followed a treatment area round and after treatment areas asked five patients what the doctor had said. Two could not say what their diagnosis was. Three could not say what would happen next. All five had nodded during the explanation. Printed leaflets existed for common conditions but were in technical language and rarely handed out.

ACTION

The Coordinator ran a 20-minute session for doctors and senior nurses on teach-back: after explaining, ask 'So that I know I explained it well, can you tell me what you'll do when you get home?' The three most common leaflets were rewritten in plain language and tested with two

patients. Nurses were asked to do a teach-back check at discharge and note it.

AFTER

The Monitor observed two consultations in which teach-back was used naturally. Discharge notes for 10 recent patients showed a teach-back check recorded. Interviewed patients could describe their condition and next step. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. After a doctor explains something, ask the patient to tell you what they heard. Note the gap.
2. Pick your three most common patient leaflets and read them as a patient would — are they clear?
3. Teach every clinician the one teach-back question: 'Can you tell me in your own words what you'll do?'
4. Add a teach-back tick box to discharge documentation.

The most common mistake: Measuring whether information was given (a leaflet, a conversation) rather than whether it was understood.

SELF-ASSESSMENT QUESTIONS

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

Evidence: Patient information materials sample

2. Is patient understanding actively verified, such as through teach-back? — *An active check, not passive delivery followed by assuming it landed.*

Evidence: N/A — tested directly

3. Are materials available in the languages patients actually need? — *Matched to actual population need.*

Evidence: Language coverage of materials

COMMON REASONS FOR A PARTIAL ANSWER

- **Plain language is used for major decisions but reverts to shorthand for routine information.** — Simplification effort concentrates on high-stakes moments.

- **Verification happens for complex decisions but not everyday instructions.** — Misunderstood routine instructions still carry real risk.
- **Materials exist in the majority language but not smaller populations served.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current materials and conversation practice for plain-language use.
Week 2	Train staff on teach-back or equivalent techniques.
Week 3	Assess language coverage against actual patient population.
Ongoing	Spot-check patient understanding periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Plain language practice check	Reviews materials and observes conversations for genuine plain-language use.
OBSERVE	Understanding verification observation	Observes whether understanding is actively checked, not assumed.
DOCUMENT	Language coverage review	Reviews materials against the languages patients actually need.

SUPERVISOR TIPS

- **Ask a patient to explain back what they were told.** — Tests actual comprehension rather than self-reported confidence.
- **Check materials for a less common language in the patient population.** — Coverage gaps concentrate exactly where they're least visible.

EVIDENCE BASE

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

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2.5 Waiting and Queue Time Is Actively Managed

CORE

Patients waiting for a consultation are managed through a defined queue system with visible, honest wait-time information, not left to wonder how long they'll wait.

In plain terms: Patients waiting for registration, triage, or an appointment are managed in a fair, visible queue, and are told honestly how long they will wait.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A waiting room without a system is a waiting room where the loudest, the most confident, or the best-connected get seen first — and the sickest quiet patient sits in the corner. Uncertainty makes waiting worse than the wait itself: patients who are told 'about 40 minutes' cope; patients told nothing become anxious, angry, or leave.

Unmanaged queues also create real clinical risk: a patient deteriorating in a corner nobody is watching. A ticket system, a whiteboard, a nurse who walks the room every 20 minutes — the mechanism matters less than that it exists, is fair, and is honest.

WHAT GOOD LOOKS LIKE

- A defined queue system operates consistently, even when busy.
- Honest wait-time information is genuinely visible.
- Staff describe an active process for monitoring

COMMON FAILURE MODES

- No defined system exists beyond who arrived first.
- No wait-time information is available, or it's routinely inaccurate.
- No mechanism exists to notice a waiting patient's condition changing.

waiting patients.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic whose outpatient department sees 300 patients a day with no queue system.

BEFORE

Patients crowded the corridor outside each consulting room. Order was by whoever pushed forward treatment area. Staff did not know how many were waiting. Complaints about queue-jumping were weekly. One patient collapsed in the corridor after waiting three hours unseen. No one could say how long the wait was on any given morning.

ACTION

The Coordinator introduced numbered tickets at registration and a whiteboard per clinic showing the number now being seen. A nurse was assigned to walk each waiting area every 30 minutes to check on anyone looking unwell. Staff were told to give an honest time estimate when asked, based on the whiteboard.

AFTER

The Monitor observed the outpatient area at 9am: tickets in use, board updated, nurse walking the room. Three patients said they had been told a wait time and it was roughly right. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Sit in your busiest waiting area for 30 minutes and watch how people are called.
2. Ask five waiting patients if anyone has told them how long they will wait.
3. Introduce the simplest system that fits: numbered tickets and a board, or a written list at the desk.
4. Assign someone to walk the waiting area at set intervals and check on anyone who looks unwell.

The most common mistake: Having a queue system on paper that staff bypass when they know a patient personally.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined queue management system, not an informal first-come approach? — *A specific, functioning system, not assumed self-evident from a waiting room.*

Evidence: Queue management description

2. Is honest wait-time information visible or communicated to waiting patients? — *Genuine, reasonably accurate information, not a vague reassurance.*

Evidence: Wait-time communication method

3. Is there a mechanism to notice if a waiting patient's condition changes? — *Active monitoring, not only queue order.*

Evidence: Waiting area monitoring process

COMMON REASONS FOR A PARTIAL ANSWER

- **The queue system works during normal hours but breaks down when busy.** — The system is most needed exactly when under the most strain.
- **Wait-time information is displayed but not updated as conditions change.** — Stale information can be worse than none.
- **Monitoring happens informally for obviously unwell patients, not systematically for everyone.**

IMPLEMENTATION PLAN

When	What
Week 1	Observe current queue practice during a known busy period.
Week 2	Establish a defined system with visible wait-time communication.
Week 3	Build a periodic waiting-area check into staff routine.
Ongoing	Review wait-time accuracy periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Queue system observation	Observes the queue system in operation during a busy period.
OBSERVE	Wait-time communication check	Checks whether wait-time information is genuinely visible and reasonably accurate.
ASK	Waiting area monitoring interview	Asks staff how they'd notice a waiting patient's condition changing.

SUPERVISOR TIPS

- **Observe during a genuinely busy period.** — Systems that work fine when quiet often reveal gaps under pressure.
- **Ask how long since the waiting area was last checked for condition changes.** — A specific answer reveals genuine practice versus a theoretical process.

EVIDENCE BASE

[9] Structured queue management and wait-time transparency are established elements of patient experience and flow-safety frameworks in ambulatory healthcare settings internationally.

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← **Ambulatory Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 1 — Access & Arrival**

Standard 3 — Environment & Shared Spaces →

ASF STANDARDS · AMBULATORY CLINIC · STANDARD 3

Standard 3 — Environment & Shared Spaces

6 criteria · 4 non-negotiable · 2 core · Version 3.0

CRITERIA IN THIS STANDARD

3.1 — Water Supply Is Safe and Monitored

3.2 — Medical Equipment Is Maintained on Schedule

3.3 — Shared Spaces Are Genuinely Clean

3.4 — Facility Risks Are Tracked in One Integrated Register

3.5 — Diagnostic Equipment On-Site Is Calibrated, Not Just Maintained

3.6 — Point-of-Care Testing Has Real Quality Control, Not Just a Working Device

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.

In plain terms: You test your water on a set schedule, keep the results, and have a plan for what to do if the supply fails or is contaminated.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Clinics use water for everything — drinking, hand hygiene, sterilisation, dialysis, cleaning wounds. If it is contaminated, every one of those becomes a route for infection. Municipal supply is not automatically safe: pipes corrode, tanks grow biofilm, pressure drops draw in groundwater. *Legionella*, *Pseudomonas*, and faecal contamination are found in clinic water systems every year, and outbreaks kill patients who were already weak. Testing costs little. Not testing and finding out through an outbreak costs lives, closures, and lawsuits. The second half — a contingency plan — matters because supply interruptions happen, and a clinic without water for six hours is a clinic in crisis.

WHAT GOOD LOOKS LIKE

- Testing happens on a defined schedule with consistent records.
- A specific, actionable contingency plan exists.
- Concerning results trigger a known, followed response process.

COMMON FAILURE MODES

- No regular testing beyond an assumption of municipal safety.
- No contingency plan exists.
- Results, when they exist, are filed without review.

WORKED EXAMPLE

IN PRACTICE

A 18-room clinic on municipal supply with a rooftop storage tank.

BEFORE

No one had tested the water in living memory. The rooftop tank had not been cleaned in four years. Staff assumed municipal water was safe. When asked what would happen if supply stopped, the facilities manager said they would 'call the water company.' There was no stored reserve for clinical use.

ACTION

The Coordinator arranged quarterly microbiological testing at a certified laboratory and had the tank drained, cleaned, and inspected. A written contingency plan named who

calls whom, where the 48-hour bottled reserve is stored, which services stop first, and how hand hygiene continues (alcohol rub stock). Results and the plan were filed in the risk register.

AFTER

The Monitor reviewed two quarters of test results (both within limits), the tank cleaning certificate, and the contingency plan. Asked a treatment area nurse what she would do if the taps stopped; she pointed to the alcohol rub and the plan on the noticeboard. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find out when your water was last tested and by whom. If nobody knows, the answer is never.
2. Book a microbiological test at a certified lab this week.
3. Look at your storage tank — when was it last cleaned?
4. Write one page: if the water stops, who does what, and where is the reserve?

The most common mistake: Trusting the municipal supply certificate and never testing what actually comes out of the clinic's own taps.

SELF-ASSESSMENT QUESTIONS

1. Is water quality tested on a defined, regular schedule, with records kept? — *An assumption is not a verified fact.*

Evidence: Water testing records

2. Is there a documented contingency plan for water supply interruption? — *A plan written during an actual interruption is not a contingency plan.*

Evidence: Contingency plan document

3. Are test results reviewed and acted on, not just filed? — *A concerning result nobody reads is no better than not testing.*

Evidence: Review and action record

COMMON REASONS FOR A PARTIAL ANSWER

- **Testing happens but with gaps during busy periods.** — Routine tasks without strong enforcement are often the first thing skipped.

- **A contingency plan exists but has never been reviewed since written.** — An untested plan may not reflect current capacity.
- **Results are reviewed informally with no documented follow-up.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current testing frequency for gaps.
Week 2	Establish a specific contingency plan for interruption.
Week 3	Define a clear response process for concerning results.
Ongoing	Review testing consistency on a fixed schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Testing record review	Reviews water testing records for consistency and whether the schedule is followed.
DOCUMENT	Contingency plan check	Reviews the plan for a real, specific backup arrangement.
ASK	Response protocol interview	Asks staff what actually happens if a test result is concerning.

SUPERVISOR TIPS

- **Ask for actual test records, not a general assurance.** — Dated records are the only real evidence of a consistent schedule.
- **Ask what happened the last time a result was concerning.** — A real example reveals more than a policy description.

EVIDENCE BASE

[10] World Health Organization, UNICEF. Water, sanitation and hygiene in health care facilities: practical steps to achieve universal access to quality care. Geneva: WHO; 2019.

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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.

In plain terms: Every piece of clinical equipment is on a maintenance schedule, gets serviced on time, and anything broken is taken out of use immediately — not left in service 'until the technician comes.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A ventilator that has not been serviced fails at 3am. An infusion pump that drifts delivers the wrong dose. A defibrillator with a flat battery is a box. Equipment failure is a leading cause of preventable patient harm and is almost entirely predictable — machines fail on schedules, which is why manufacturers publish service intervals. The harder discipline is removing faulty equipment from use. It is tempting to keep a monitor with an intermittent fault in service because there is no spare. That is how a known fault becomes a death. Tag it, remove it, find a workaround. Equipment that is 'mostly working' is not working.

WHAT GOOD LOOKS LIKE

- A comprehensive schedule is consistently followed.
- Faulty equipment is physically removed from use immediately.
- A named person owns the programme confidently.

COMMON FAILURE MODES

- Maintenance happens reactively, only after failure.
- Faulty equipment remains available and sometimes used.
- Nobody can identify who is responsible.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic with 400 items of clinical equipment and one biomedical technician.

BEFORE

There was no equipment inventory. Servicing happened when something broke. Three infusion pumps with known faults were still in use on the treatment areas because there were no replacements. A ventilator in ICU was 14 months overdue for service. Staff had no way to report a fault except to tell the technician verbally.

ACTION

The Coordinator and technician built a spreadsheet inventory of every clinical item with its service interval and next due date. Overdue items were prioritised by risk — ventilators and pumps first. A red 'DO NOT USE' tag system was introduced; any staff member could tag and remove a faulty item and log it. The three faulty pumps were tagged and removed the same day; two were repaired, one condemned.

AFTER

The Monitor sampled 20 items from the inventory: all had a service record and none were overdue. Found one tagged monitor in the equipment store with a logged fault. Asked two nurses how they would report a fault; both described the tag system. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk the treatment areas and count clinical equipment. If you have no inventory, start one today.
2. Ask staff: is any equipment in use that you know has a fault? Remove it now.
3. Find the service interval for your highest-risk items (ventilators, pumps, defibrillators) and check when they were last done.
4. Give every treatment area a stack of 'DO NOT USE' tags and tell staff they have authority to use them.

The most common mistake: Keeping equipment with a known fault in service because there is no replacement — a known fault is worse than no equipment, because staff rely on it.

SELF-ASSESSMENT QUESTIONS

1. Is there a documented maintenance schedule covering all clinical equipment? — *A defined, proactive schedule, not reactive maintenance.*

Evidence: Maintenance schedule and log

2. Is faulty equipment actually removed from use, not kept accessible awaiting repair? — *A tag alone isn't sufficient if the equipment remains physically accessible.*

Evidence: Removal-from-service record

3. Is there a named person responsible for the maintenance programme? — *Diffuse responsibility usually means inconsistency.*

Evidence: Role assignment record

COMMON REASONS FOR A PARTIAL ANSWER

- **A schedule exists for major equipment but not smaller items.** — Coverage often reflects value or visibility rather than actual risk.
- **Faulty equipment is tagged but not physically relocated.** — A tag depends on every staff member noticing it every time.
- **Responsibility sits with someone who has since changed roles informally.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit equipment against the maintenance schedule for gaps.
Week 2	Establish a process for physically removing faulty equipment.
Week 3	Name a specific owner of the programme.
Ongoing	Review maintenance log currency against the schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Maintenance schedule review	Reviews the schedule and log for completeness and consistency.
OBSERVE	Faulty equipment check	Checks whether flagged equipment remains physically accessible.
ASK	Responsible person interview	Asks whoever is responsible to describe the actual process.

SUPERVISOR TIPS

- **Look for equipment that should be flagged but isn't.** — The absence of any flagged equipment is itself worth questioning.
- **Check whether tagged equipment is still physically reachable.** — A tag alone doesn't prevent use if it sits in its normal location.

EVIDENCE BASE

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

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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.

In plain terms: Shared areas are cleaned on a documented schedule, and you can prove cleanliness with more than 'it looks clean today.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Surfaces look clean long after they stop being clean. A waiting-room chair wiped once a week harbours what every patient who sat on it left behind. Infection spreads on door handles, bed rails, and toilet flush handles that appear spotless. The standard asks for two things: a schedule — who cleans what, how often, with what — and verification that goes beyond the eye. That can be as simple as a supervisor sign-off checklist, or as rigorous as ATP swab testing. Either way, 'we clean every day' is a claim; a log with signatures and a spot-check is evidence.

WHAT GOOD LOOKS LIKE

- A documented, consistently followed schedule covers all shared spaces.
- High-touch surfaces are specifically addressed.
- Cleanliness is verified through a defined process.

COMMON FAILURE MODES

- No documented schedule beyond good intentions.
- High-touch surfaces show visible neglect.
- Verification is undocumented and inconsistent.

WORKED EXAMPLE

IN PRACTICE

A 8-room clinic with an outsourced cleaning contractor.

BEFORE

The contractor cleaned to their own plan, which nobody at the clinic had seen. There was no log. When the Coordinator asked which surfaces were cleaned in the waiting area and how often, no one could say. A visual check on the day looked fine. An ATP swab of the main waiting-room door handle returned a reading four times the acceptable threshold.

ACTION

The Coordinator obtained the contractor's schedule, revised it with infection control to specify high-touch surfaces and frequency, and

required a signed daily log per area. The treatment area sister spot-checked one area per day with a 10-point checklist. Monthly ATP swabs of five high-touch points were added, with results recorded.

AFTER

The Monitor reviewed three months of daily logs and ATP results (all within threshold after month one). Observed a cleaner following the schedule and a supervisor checking the log. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask who cleans your main waiting area, how often, and where it is written down.
2. Get the cleaning schedule — if there isn't one, that is the first gap.
3. Add a signed daily log for each area, kept where the supervisor can see it.
4. Start spot-checking: one area a day, ten points, initialled.

The most common mistake: Relying on a visual inspection on the assessment day, which proves nothing about the other 364.

SELF-ASSESSMENT QUESTIONS

- 1.** Is there a documented cleaning schedule with records kept? — *A specific, dated schedule, not a general statement.*

Evidence: Cleaning schedule and log

- 2.** Is cleaning verified through more than a visual check? — *Visual cleanliness and actual microbial cleanliness aren't the same thing.*

Evidence: Verification or audit record

- 3.** Are high-touch surfaces specifically included? — *Door handles and switches are easy to overlook relative to visible surfaces.*

Evidence: High-touch surface schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **A schedule exists for the waiting room but not less-visited areas.** — Peripheral areas often receive less consistent attention.

- **Cleaning happens but high-touch surfaces aren't specifically called out.** — A general routine can miss the surfaces that matter most.
- **Verification exists informally with no documentation.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current schedules for coverage gaps.
Week 2	Add specific high-touch surface cleaning to the schedule.
Week 3	Establish a simple verification step.
Ongoing	Audit cleaning log completeness periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Cleaning schedule review	Reviews the schedule against completion records.
OBSERVE	High-touch surface check	Checks whether high-touch surfaces are specifically addressed.
ASK	Verification process interview	Asks staff how cleanliness is actually verified.

SUPERVISOR TIPS

- **Check high-touch surfaces specifically.** — Door handles and switches reveal more than open floor areas.
- **Ask for the log, not a general assurance.** — Dated records are the only real evidence.

EVIDENCE BASE

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

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3.4 Facility Risks Are Tracked in One Integrated Register

NON-NEGOTIABLE

Water safety, fire safety, and equipment maintenance data feed into one integrated risk register, not separate untracked lists.

In plain terms: All facility risks — water, fire, equipment, building — are listed in one risk register that someone reviews regularly, instead of scattered across separate checklists nobody connects.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

A clinic has dozens of risks that each live in someone's drawer: the fire officer's checklist, the water test folder, the equipment log, the building survey. Nobody sees them together. So nobody notices that the emergency generator (equipment) sits in a room with a leaking pipe (building) below the fire alarm panel (fire). A single register forces the question: what are our top ten risks right now, and who owns each? It turns a pile of compliance paperwork into a management tool. It also protects the Director — a reviewed register is evidence that risks were known and managed, not ignored.

WHAT GOOD LOOKS LIKE

- Facility risks feed into one integrated register.
- The register is reviewed on a defined schedule.
- Risks are prioritised, with highest-risk items addressed first.

COMMON FAILURE MODES

- Records exist as entirely separate, unconnected logs.
- No defined review schedule exists.
- All items are treated with equal, undifferentiated priority.

WORKED EXAMPLE

IN PRACTICE

A 16-room clinic with fire, water, equipment, and building risks tracked by four different people.

BEFORE	Each department kept its own list. The Director had never seen them together. When the Coordinator collected them, she found the backup generator was overdue for service, the fuel store had a fire-rating issue, and the fire officer had flagged the generator room as a risk — three findings, three files, no connection, no action.
ACTION	The Coordinator built one register: risk, likelihood, impact, owner, current controls, next action, review date. She populated it from the four existing lists, scored each, and sorted by priority. The top ten went to the management meeting monthly. The generator issue was resolved in three weeks once all three findings were seen together.
AFTER	The Monitor reviewed the register: 34 risks, each with an owner and a dated review. Minutes of two management meetings showed the top ten discussed and actions closed. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Collect every existing risk list, checklist, and audit finding from every department into one folder.
2. Put them in one table: risk, how likely, how bad, who owns it, what's being done.
3. Score and sort — what are your top ten?
4. Put the top ten on the next management meeting agenda and set a review date.

The most common mistake: Building the register once for accreditation and never reviewing it — a register with a review date two years old is a historical document.

SELF-ASSESSMENT QUESTIONS

1. Do water safety, fire safety, and equipment data feed into one register? — *A single place to see the whole risk picture, not scattered logs.*

Evidence: Integrated risk register document

2. Is the register reviewed on a defined schedule by clinic leadership? — *Review at a level that can act across domains.*

Evidence: Review meeting record

3. Does the register prioritise risks, not just list them? — *A genuine tool ranks what needs attention first.*

Evidence: Risk prioritisation criteria

COMMON REASONS FOR A PARTIAL ANSWER

- **Individual domain tracking is strong but nothing integrates them.** — Good individual records don't automatically produce a combined view.
- **A register exists but review happens irregularly.** — An ad hoc pattern risks the register becoming stale.
- **The register lists risks without ranking them.**

IMPLEMENTATION PLAN

When	What
Week 1	Inventory current safety tracking across domains.
Week 2	Consolidate into one integrated register.
Week 3	Establish a defined review schedule.
Ongoing	Review and reprioritise on schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Register completeness review	Reviews integration across safety domains.
DOCUMENT	Review schedule check	Checks for evidence of defined-schedule review.
ASK	Prioritisation interview	Asks how risks are prioritised, not just logged.

SUPERVISOR TIPS

- **Ask to see the register itself, not descriptions of individual tracking.** — Integration itself is what this checks.
- **Ask who reviews it and how often, specifically.** — A specific process is the real evidence of active use.

EVIDENCE BASE

[13] Integrated environment-of-care risk management, tying individual facility safety domains into one reviewed register, is an established approach in international facility safety frameworks.

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3.5 Diagnostic Equipment On-Site Is Calibrated, Not Just Maintained CORE

Any diagnostic equipment on-site — X-ray, ultrasound, ECG — is calibrated against a defined schedule, verified for accuracy, not just confirmed to be running.

In plain terms: X-ray, ultrasound, ECG and other diagnostic equipment is calibrated on a schedule and checked for accuracy — not just confirmed to switch on.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

An ECG machine that is running but miscalibrated produces a trace that looks normal and misses an arrhythmia. An ultrasound with a degraded probe misses a mass. An X-ray unit delivering more dose than displayed exposes every patient to unnecessary radiation. Maintenance keeps the machine running; calibration keeps it accurate. They are different things done by different people on different schedules. A clinic that cannot show when its diagnostic equipment was last calibrated does not know whether its results are true.

WHAT GOOD LOOKS LIKE

- Equipment is calibrated on a defined schedule by a qualified source.
- Calibration certificates are current and retained.
- Miscalibrated equipment is genuinely removed from use until corrected.

COMMON FAILURE MODES

- No calibration schedule exists beyond general maintenance.
- Calibration, if claimed, has no verifiable certificate.
- Equipment continues in use despite known calibration issues.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic with an ECG, a portable ultrasound, and a dental X-ray unit.

BEFORE

The ECG had been 'serviced' two years earlier — a cleaning and a new cable. It had never been calibrated against a reference signal. The ultrasound probe had a dead zone the operator had learned to work around. The X-ray unit had no dose verification record. All three were 'working.'

ACTION

The Coordinator identified the manufacturer's calibration interval for each device and arranged a calibration visit from a certified biomedical engineer. The ECG was found 8% out; the ultrasound probe was replaced; the X-ray unit's dose was verified within tolerance. A calibration schedule with next-due dates was added to the equipment inventory, separate from the maintenance schedule.

AFTER

The Monitor reviewed calibration certificates for all three devices and the schedule showing next due dates. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every diagnostic device you own.

2. For each, find the manufacturer's recommended calibration interval.
3. Find the last calibration certificate. If there is none, that is the gap.
4. Book a certified calibration visit and add the next-due date to your inventory.

The most common mistake: Treating an annual service as calibration — the technician who cleaned the machine did not verify its accuracy.

SELF-ASSESSMENT QUESTIONS

1. Is diagnostic equipment calibrated against a defined schedule, not just confirmed to be running? — *Calibration verifies accuracy; maintenance only verifies function.*

Evidence: Calibration schedule and log

2. Is calibration performed or verified by a qualified, external or certified source? — *Self-assessed calibration by untrained staff doesn't meet this.*

Evidence: Calibration certificate

3. Is equipment found out of calibration removed from use until corrected? — *Continuing to use miscalibrated equipment defeats the purpose of checking at all.*

Evidence: Removal-from-service record

COMMON REASONS FOR A PARTIAL ANSWER

- **Calibration happens for the primary diagnostic device but not secondary equipment.** — Attention often concentrates on the most visible or expensive equipment.
- **Calibration certificates exist but are past their valid period.** — An expired certificate provides no current assurance.
- **Miscalibration is noted but correction is delayed without removing the equipment from use.**

IMPLEMENTATION PLAN

When	What
Week 1	Inventory all diagnostic equipment and current calibration status.

When	What
Week 2	Schedule calibration with a qualified source for any equipment overdue.
Week 3	Establish a removal-from-service rule for miscalibrated equipment.
Ongoing	Track calibration certificate expiry proactively.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Calibration record review	Reviews calibration certificates and schedule adherence.
DOCUMENT	Qualified source check	Confirms calibration is performed by a qualified, certified source.
OBSERVE	Out-of-calibration handling check	Checks whether equipment found miscalibrated is genuinely removed from use.

SUPERVISOR TIPS

- **Ask for the calibration certificate itself, not a statement that equipment works.** — A certificate from a qualified source is the only real evidence of genuine calibration.
- **Check certificate dates against the actual current date.** — An expired certificate is a common, specific gap worth checking directly.

EVIDENCE BASE

[14] Calibration verification, distinct from general equipment maintenance, is an established requirement in diagnostic equipment quality frameworks specifically because functional equipment can still produce inaccurate output.

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3.6 Point-of-Care Testing Has Real Quality Control, Not Just a Working Device

NON-NEGOTIABLE

Any point-of-care test performed on-site — rapid strep, glucose, pregnancy, or similar — is run against a documented quality control process, not assumed accurate because the device powers on.

In plain terms: Every rapid test done in the clinic — glucose, strep, pregnancy, urine dip — has a quality control process with records, not just a device that turns on.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Point-of-care tests are trusted because they are simple. That trust is misplaced when the glucose meter has drifted, the strep kit is expired, or the strips were stored in a hot cupboard. A wrong result at the point of care is acted on immediately — insulin given, antibiotics started, a pregnancy missed — before anyone has a chance to question it. Quality control means running a control sample of known value at defined intervals (daily for meters, per lot for kits), recording the result, and not using the device or kit if the control fails. It takes two minutes. Without it, the clinic is guessing.

WHAT GOOD LOOKS LIKE

- A documented quality control process runs consistently for every point-of-care test type.
- Staff are specifically trained and assessed as competent for the tests they perform.
- A quality control failure stops patient testing until resolved.

COMMON FAILURE MODES

- No quality control process exists beyond the device appearing to work.
- Staff perform tests with no specific training or competency assessment.
- Quality control failures, if noticed, don't stop patient testing.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic running glucose, urine dipstick, rapid strep, and pregnancy tests daily.

BEFORE	No QC was run on any test. Glucose strips were stored on a windowsill. One box of strep kits was six months past expiry. The Coordinator ran a control solution through the glucose meter: it read 15% high. Patients had been managed on that meter for months.
ACTION	A QC log was created per test type: glucose meter control run every morning before patient use; strep and pregnancy kits checked with the built-in control on every lot and daily visual check of expiry; urine dips stored per manufacturer and control strip run weekly. Any control failure stops use of that device or lot until resolved. Strips were moved to a cupboard away from heat.
AFTER	The Monitor reviewed six weeks of QC logs: complete, with one glucose control failure documented and the meter replaced. All kits in date. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every rapid test you run.
2. Check every kit and strip box for expiry today.
3. Run a control solution through your glucose meter this morning.
4. Start a QC log per test — one line per day.

The most common mistake: Assuming a rapid test is accurate because it is simple — simple tests fail silently.

SELF-ASSESSMENT QUESTIONS

1. Is a documented quality control process run for each point-of-care test type, not just assumed from the device working? — *A specific control sample check, not confirmation the device turns on.*

Evidence: Quality control log

2. Are staff performing point-of-care tests specifically trained and assessed as competent? — *Training specific to the test, not general*

clinical competence.

Evidence: Staff training and competency record

3. Are quality control failures acted on before patient results are reported? — A failed control that doesn't stop patient testing provides no real protection.

Evidence: Quality control failure response record

COMMON REASONS FOR A PARTIAL ANSWER

- **Quality control is run for the most frequently used test but not less common ones.** — Attention concentrates on high-volume tests, leaving others under-checked.
- **Staff were trained once at introduction but never reassessed.** — Competency can drift without periodic reassessment.
- **A failed control is documented but patient testing continues regardless.**

IMPLEMENTATION PLAN

When	What
Week 1	Inventory all point-of-care tests performed and current quality control practice.
Week 2	Establish a documented quality control process for every test type.
Week 3	Train and formally assess staff competency for each test performed.
Ongoing	Audit quality control log completeness periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Quality control log review	Reviews the quality control log for consistency and completeness per test type.
DOCUMENT	Staff competency review	Reviews training and competency assessment records for staff performing point-of-care testing.
ASK	Failure response interview	Asks staff what happens when a quality control check fails.

SUPERVISOR TIPS

- **Ask for the actual quality control log, not a description of the testing process.** — Dated records are the only real evidence of a consistent process.
- **Ask what happens specifically when a control fails.** — A real, specific answer reveals whether this is genuine practice or assumed.

EVIDENCE BASE

[15] International Organization for Standardization. ISO 15189:2022 — Medical laboratories: requirements for quality and competence. Geneva: ISO; 2022 — establishes quality control requirements specifically applicable to point-of-care testing, distinct from centralised laboratory testing.

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← **Ambulatory Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 2 — Reception & Information**

Standard 4 — Care & Treatment →

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ASF STANDARDS · AMBULATORY CLINIC · STANDARD 4

Standard 4 — Care & Treatment

12 criteria · 12 non-negotiable · 0 core · Version 3.0

CRITERIA IN THIS STANDARD

- 4.1 — Consent Is Real, Not a Signature
- 4.2 — Staff Credentials Are Checked and Current
- 4.3 — Hand Hygiene Actually Happens
- 4.4 — Every Patient Gets a Real Assessment
- 4.5 — Medication Prescribing Is Safe
- 4.6 — Patient Identified Correctly at Every Point of Contact
- 4.7 — A Defined, Working Referral Relationship With a Named Receiving Facility
- 4.8 — Referral Follow-Through Is Confirmed, Not Assumed
- 4.9 — Every Test Result Reaches the Patient, Abnormal or Not
- 4.10 — A Chaperone Is Genuinely Offered for Every Sensitive Examination
- 4.11 — Dignity, Respect, and Non-Discrimination Are Practised, Not Just Stated
- 4.12 — Reusable Equipment Is Cleaned and Sterilised Between Patients

4.1 Consent Is Real, Not a Signature

Before any procedure, the patient has a genuine conversation about what will happen, why, and what the alternatives are, and can explain it back in their own words — not a form signed without real understanding.

In plain terms: Before any significant procedure, a real conversation happens about risks, benefits and alternatives — and the patient can tell you what they were told.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A signature on a consent form is not consent. Consent is understanding — the patient knows what will be done, what could go wrong, and what else they could choose. Without that, a bad outcome becomes a betrayal, not a known risk accepted. Legally, in almost every jurisdiction, a signed form obtained without genuine explanation is not valid consent, and courts increasingly ask what the patient was actually told. Clinically, patients who understand their procedure recover better and follow instructions more closely. The test is not the form; it is whether the patient, asked ten minutes later, can describe the risks in their own words.

WHAT GOOD LOOKS LIKE

- A genuine conversation happens before every procedure.
- Patients can explain back what will happen and why.
- Alternatives and the right to decline are genuinely discussed.

COMMON FAILURE MODES

- A form is presented for signature with no real conversation.
- Patients cannot explain what they agreed to.
- Only one path is presented, with no genuine alternative discussed.

WORKED EXAMPLE

IN PRACTICE

A 20-room clinic where surgical consent is obtained on the morning of surgery by a junior doctor.

BEFORE

The Coordinator interviewed five patients after consent was signed. Four could not name a single risk. One thought the operation had no risks 'because the doctor said it was routine.' Consent forms were complete and signed. The consenting doctor was often a junior who had not been present at the diagnosis and spent under two minutes per patient.

ACTION

Surgical consent was moved to the pre-registration clinic, taken by the operating surgeon or senior registrar, using a one-page plain-language sheet per common procedure listing the three most important risks and the alternatives. Patients keep the sheet. A teach-back question ('What could go wrong with this operation?') is asked and the answer noted.

AFTER

The Monitor interviewed six pre-operative patients: all could name at least two risks and the alternative. Consent forms showed teach-back notes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three patients who have just signed consent: 'What could go wrong?' Write down their answers.
2. Time how long the consent conversation actually takes.
3. For your five most common procedures, write a one-page plain-language sheet: what, risks, alternatives.
4. Add a teach-back line to the consent form: 'Patient described risks as: ____'.

The most common mistake: Measuring whether the consent form is signed rather than whether the patient understood anything.

SELF-ASSESSMENT QUESTIONS

1. Does a genuine conversation happen before the procedure, not just a form handed over? — *An actual explanation, not a document presented for signature.*

Evidence: N/A — tested directly

2. Can the patient explain back, in their own words, what will happen and why? — *Tests genuine understanding, not just that a conversation occurred.*

Evidence: N/A — tested directly

3. Are alternatives and the option to decline genuinely discussed? — *Consent that only presents one path isn't genuinely informed.*

Evidence: Consent documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Conversation happens for major procedures but is rushed for routine ones.** — Routine-seeming procedures still deserve genuine understanding.
- **Understanding is assumed from the patient nodding along.** — A nod doesn't confirm genuine comprehension.
- **Alternatives are mentioned but not genuinely explored.**

IMPLEMENTATION PLAN

When	What
Week 1	Observe current consent practice for genuine conversation versus form presentation.
Week 2	Train staff on teach-back verification for consent specifically.
Week 3	Build alternatives discussion into the standard consent process.
Ongoing	Spot-check patient understanding after consent conversations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Consent conversation observation	Observes an actual consent conversation for genuine explanation, not form presentation.

Method	What	Detail
ASK	Patient understanding check	Asks a patient to explain back what they understood about their procedure.
DOCUMENT	Alternatives documentation review	Reviews whether alternatives and the right to decline are documented as discussed.

SUPERVISOR TIPS

- **Ask the patient, not the clinician, to explain the procedure.** — This tests actual understanding, not staff confidence in their own explanation.
- **Check for rushed consent on routine procedures specifically.** — This is where genuine practice most commonly erodes.

EVIDENCE BASE

[16] World Health Organization. WHO guidelines for safe surgery 2009: safe surgery saves lives. Geneva: WHO; 2009.

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4.2 Staff Credentials Are Checked and Current

NON-NEGOTIABLE

Every clinical staff member's licence and credentials are verified directly with the issuing body and kept current, not accepted on the staff member's own word.

In plain terms: You have verified every clinical staff member's qualifications directly with the issuing body — not just accepted their certificate — and the records are current.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Fake medical degrees and forged nursing licences are not rare. Every year, unqualified individuals are found practising in clinics that accepted a photocopy and never checked. The harm to patients is obvious; the harm to the clinic — legal, financial, reputational — can be fatal. Verification means contacting the university, the licensing board, or the registry and confirming: this person, this qualification, this date. It takes an email. Not doing it means the clinic has no idea who is actually treating its patients. 'Current' matters too: licences lapse, registrations expire, and a nurse practising on an expired licence exposes the clinic equally.

WHAT GOOD LOOKS LIKE

- Every credential is verified directly with the issuing body.
- Currency is rechecked on a defined periodic schedule.
- A clear response protocol exists for a lapsed credential.

COMMON FAILURE MODES

- Credentials are accepted on presentation without direct verification.
- No periodic recheck happens after hiring.
- No defined process exists if a lapse is discovered.

WORKED EXAMPLE

IN PRACTICE

A 6-room clinic with 85 clinical staff and an HR file for each.

BEFORE

Each file contained a photocopied degree and licence. Nobody had contacted an issuing body. The Coordinator picked ten files at random and checked with the medical council: nine confirmed, one physician's registration had lapsed 14 months earlier. He was still prescribing.

ACTION

HR was given a verification form: for each clinical staff member, the issuing body was contacted and the response filed. Every licence expiry date went into a spreadsheet with a 60-day reminder. The lapsed physician was suspended from clinical duties until re-registered.

AFTER

The Monitor sampled 15 files: each had a written confirmation from the issuing body and a current licence. The expiry spreadsheet showed no lapses. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pick ten clinical staff files at random and check for evidence of direct verification — not just a certificate copy.
2. For any without it, email the licensing body this week.
3. Put every licence expiry date in one spreadsheet with a 60-day warning.
4. Decide now what happens if you find a lapsed licence — and follow it.

The most common mistake: Accepting a certificate as proof of qualification — a certificate proves only that a piece of paper exists.

SELF-ASSESSMENT QUESTIONS

1. Is every clinical staff credential verified directly with the issuing body, not just filed on presentation? — *Direct verification, not trust in a presented document alone.*

Evidence: Verification record

2. Is credential currency rechecked periodically, not only at hiring? — *A licence can lapse after hiring without anyone noticing.*

Evidence: Periodic recheck schedule

3. Is there a defined process if a credential is found lapsed or invalid? — *Discovery without a defined response provides no real protection.*

Evidence: Response protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens at hiring but is never repeated.** — A credential valid at hiring can lapse years into employment.
- **Verification happens for physicians but less consistently for other clinical staff.** — Coverage often concentrates on the most visible role.

- A response protocol exists but has never actually been used or tested.

IMPLEMENTATION PLAN

When	What
Week 1	Audit current credential verification practice for all clinical staff.
Week 2	Establish direct verification with issuing bodies where not already done.
Week 3	Set a periodic recheck schedule.
Ongoing	Review credential currency on the defined schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Verification record review	Reviews evidence credentials were verified directly with the issuing body.
DOCUMENT	Recheck schedule review	Reviews whether currency is rechecked periodically, not only at hiring.
ASK	Response protocol interview	Asks what happens if a credential is found lapsed.

SUPERVISOR TIPS

- **Ask how verification was done for a specific staff member, by name.** — A specific example reveals whether this is genuine practice.
- **Ask about non-physician clinical staff specifically.** — Coverage often concentrates on physicians, leaving other roles less verified.

EVIDENCE BASE

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

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4.3 Hand Hygiene Actually Happens

NON-NEGOTIABLE

Hand hygiene is performed at the correct moments, verified through direct observation, not assumed from the presence of sinks or sanitiser dispensers.

In plain terms: Hand hygiene stations are at the bedside and at every point of care — and staff use them, when observed and when not.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Hand hygiene is the single most effective infection prevention measure known, and the single most frequently failed. Healthcare-associated infections affect one in ten patients in low- and middle-income countries; most are transmitted on hands. Compliance in unobserved conditions is typically half what it is when staff know they are watched. The standard asks for two things: the physical means — dispensers at every point of care, filled, working — and the behaviour, observed at times staff do not expect. A clinic that measures hand hygiene only when the infection control nurse is standing on the treatment area is measuring performance, not practice.

WHAT GOOD LOOKS LIKE

- Hand hygiene is consistently performed at the correct moments.
- Stations are genuinely accessible at the point of care.
- Compliance is directly observed and audited periodically.

COMMON FAILURE MODES

- Hand hygiene is inconsistent or skipped under time pressure.
- Stations exist but are inconveniently placed.
- Compliance is assumed, never actually observed.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic with alcohol rub dispensers at treatment area entrances only.

BEFORE

Dispensers were at the door of each treatment area, not at bedsides. Staff had to walk 15 metres to clean hands between patients; most did not. A covert observation by the Coordinator over one hour showed 22% compliance with the WHO Five Moments. Two of four dispensers were empty.

ACTION

Dispensers were installed at every bed and every trolley. A daily refill check was added to the cleaner's log. Monthly covert observation by a rotating team member (not infection control) was introduced, with results by treatment area shown on a board. Ward managers received feedback within 48 hours.

AFTER

The Monitor conducted an unannounced 30-minute observation: 78% compliance. All dispensers checked were full. Three months of observation data showed a rising trend. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Stand at a bedside — can you reach a hand rub without walking? If not, that is the first fix.
2. Do one covert 30-minute observation on a treatment area, counting opportunities and actions.
3. Check every dispenser: is it full and working?
4. Add a refill check to the daily cleaning log.

The most common mistake: Measuring compliance only during announced audits, which reliably shows double the real rate.

SELF-ASSESSMENT QUESTIONS

1. Is hand hygiene performed before and after every patient contact, not just when convenient? — *Every contact, not a general habit applied*

inconsistently.

Evidence: N/A — tested directly

2. Are sanitiser or handwashing stations genuinely accessible at the point of care? — *Accessible at the moment needed, not down the hall.*

Evidence: Photo of station placement

3. Is hand hygiene compliance directly observed periodically, not assumed? — *Direct observation, not reliance on self-report.*

Evidence: Observation audit record

COMMON REASONS FOR A PARTIAL ANSWER

- **Compliance is strong for obvious contacts but weaker for brief interactions.** — Perceived low-risk contacts often receive less consistent attention.
- **Stations exist but are sometimes out of supply.** — An empty dispenser provides no real protection.
- **Audits happen but only during announced observation periods.**

IMPLEMENTATION PLAN

When	What
Week 1	Conduct an unannounced observation of current hand hygiene practice.
Week 2	Address any station accessibility or supply gaps found.
Week 3	Establish a periodic, partly unannounced audit schedule.
Ongoing	Track compliance trends and address any decline.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Direct hand hygiene observation	Observes actual hand hygiene practice during patient contacts.
OBSERVE	Station accessibility check	Checks that stations are genuinely accessible at the point of care.
DOCUMENT	Compliance audit review	Reviews periodic compliance audit records.

SUPERVISOR TIPS

- **Observe unannounced, not during a scheduled audit.** — Announced observation can produce artificially high compliance.
- **Check dispenser supply levels directly.** — An empty dispenser is a common, easily missed gap.

EVIDENCE BASE

[18] World Health Organization. WHO guidelines on hand hygiene in health care. Geneva: WHO; 2009.

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4.4 Every Patient Gets a Real Assessment

NON-NEGOTIABLE

Every patient receives a genuine clinical assessment appropriate to their presenting concern, performed by a qualified clinician and drawing in other relevant disciplines where the presentation calls for it, documented specifically, not a generic note applied regardless of the actual visit. The resulting treatment plan states its goal and is set with the patient's genuine involvement, not decided and only announced to them.

In plain terms: Every admitted patient gets a proper, structured clinical assessment on arrival — not a form filled in to satisfy the record.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The registration assessment is where you find the things that will kill the patient if missed: the allergy, the anticoagulant, the pressure sore already forming, the fall last week, the confusion that is actually sepsis. A structured assessment forces the clinician to look for each of these

systematically. An unstructured one relies on the clinician remembering to ask — and under pressure, they do not. Documentation that is complete but done by copying the referral letter is worse than none, because it looks like an assessment happened. The test is whether the assessment finds things the patient did not volunteer.

WHAT GOOD LOOKS LIKE • Assessments are specific to each patient's actual presentation. • Documentation happens at the time of the visit. • A different clinician can understand what was found from the record.	COMMON FAILURE MODES • Assessments read as generic templates regardless of the actual visit. • Documentation is reconstructed well after the visit. • A different clinician cannot tell what was actually found.
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WORKED EXAMPLE

IN PRACTICE <i>A 16-room clinic where registration assessments were a free-text note in the medical record.</i>	
BEFORE	The Coordinator reviewed 20 recent registration notes. Twelve had no documented allergy check. Eight had no falls history. Six had no medication list. Three patients had pressure injuries documented by nurses on day two that were not noted on registration. Doctors said they 'assessed everything' but the notes did not show it.
ACTION	A one-page structured registration template was introduced: allergies, medications, falls, pressure risk, nutrition, VTE risk, cognition, and reason for registration — each with a mandatory field. It was piloted on one treatment area for two weeks, revised, then rolled out. The template became the first page of every registration record.
AFTER	The Monitor reviewed 20 recent registrations: all used the template with all fields completed. Two

showed allergies discovered at registration that the referral had not mentioned. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 20 recent registration notes and check: allergy, medications, falls, pressure risk — how many are documented?
2. Ask one admitting doctor to walk you through their assessment; note what they skip.
3. Build a one-page template covering the eight essentials.
4. Pilot it on one treatment area, then make it the first page of every record.

The most common mistake: Having a template that gets filled in from the referral letter without examining the patient.

SELF-ASSESSMENT QUESTIONS

1. Is the assessment specific to this patient's actual presenting concern, not a generic template? — *Genuinely reflects what was found, not a copied general note.*

Evidence: Assessment record sample

2. Is the assessment documented at the time of the visit, not reconstructed later? — *Contemporaneous documentation is more reliable than reconstruction.*

Evidence: Documentation timestamp

3. Would another clinician reading this assessment understand what was actually found? — *Tests genuine usefulness to a future reader, not just completion.*

Evidence: N/A — tested directly

4. Is the assessment performed by someone genuinely qualified to perform it, with other relevant disciplines drawn in where the case warrants it? — *A named, qualified assessor, with real multidisciplinary input when complexity calls for it.*

Evidence: Assessor qualification record

5. Does the visit record state an explicit treatment goal, and was the patient genuinely involved in setting it? — *A real, stated goal and genuine patient involvement, not a list of instructions with no stated*

purpose.

Evidence: Visit record, patient interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Assessments are specific for complex presentations but generic for routine ones.** — Perceived complexity often determines documentation effort.
- **Documentation happens same-day but not at the actual time of assessment.** — Even same-day reconstruction can lose accuracy.
- **Assessments are specific but use abbreviations unclear to other staff.**

IMPLEMENTATION PLAN

When	What
Week 1	Review a sample of recent assessments for genuine specificity.
Week 2	Reinforce contemporaneous documentation practice.
Week 3	Standardise abbreviation use for cross-staff readability.
Ongoing	Periodically review assessment quality across different clinicians.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Assessment specificity review	Reviews a sample of assessments for genuine, patient-specific content.
DOCUMENT	Timing review	Checks documentation timestamps against actual visit time.
ASK	Clinician readability interview	Asks a different clinician to review a sample assessment and describe what it tells them.

SUPERVISOR TIPS

- **Compare two assessments from the same clinician for different patients.** — Genuinely different content reveals real specificity; near-identical text reveals a template.

- **Ask a different staff member to interpret a sample record.** — Tests real readability, not just the original author's understanding.

EVIDENCE BASE

[19] Individualised, documented care assessment is consistently associated with improved continuity of care across providers in health services literature, distinct from assessment quality alone.

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4.5 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.

In plain terms: Prescriptions are legible, checked, and follow a safety process — with a second trained person checking every high-risk drug.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Adapted	Full	Full

WHY THIS MATTERS

Medication errors are the most common preventable harm in clinics. Most originate at prescribing: illegible handwriting, wrong dose, wrong unit, missed interaction, missed allergy. A second check catches the majority — but only if it is a real check by someone trained to know what to look for, not a signature from whoever is nearest. High-risk medications — insulin, anticoagulants, opioids, chemotherapy, concentrated electrolytes — deserve a mandatory independent double-check because a single error can kill. The process must be defined: who checks, what they check, how it is recorded.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Prescriptions are consistently legible and complete.
- A genuine, independent second check happens for high-risk medications.
- The second-check role is named and specifically trained, whoever holds it.

- Prescriptions are frequently illegible or ambiguous.
- No independent second check exists for high-risk medications.
- No one is specifically trained for the second-check function.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic with handwritten prescriptions and no defined checking process.

BEFORE	The Coordinator reviewed 50 prescription charts. Seven had entries the pharmacist could not read. Four had no route. Two had a dose in mg where mcg was intended. There was no list of high-risk drugs and no second-check requirement. Nurses said they 'checked with each other sometimes.'
ACTION	A prescribing standard was written: printed name, drug, dose, route, frequency, and signature on every entry; unclear entries returned unfilled. A high-risk drug list (eight classes) was posted in every clinical area with a mandatory two-signature check before administration. Pharmacy began a daily review of all new prescriptions on two pilot treatment areas.
AFTER	The Monitor reviewed 40 charts: all legible and complete. Observed an insulin administration with independent double-check. Pharmacy intervention log showed 30 errors caught in two months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 30 prescription charts and check: can a pharmacist read every entry? Is every dose, route and frequency present?

2. Write a list of the eight to ten high-risk drug classes and post it in every clinical area.
3. Require two signatures before any high-risk drug is given.
4. Ask pharmacy to review new prescriptions on one treatment area for a month and log what they catch.

The most common mistake: Calling a colleague's glance a 'double-check' — a check by someone who does not know what to look for catches nothing.

SELF-ASSESSMENT QUESTIONS

1. Are prescriptions legible and complete, with dose, route, and frequency unambiguous? — *Illegibility itself is a preventable safety risk.*

Evidence: Prescription sample

2. Is there a genuine second check for high-risk medications by a trained, designated person? — *Independent, not the same person confirming their own work.*

Evidence: Second-check record

3. Who performs the second check, and are they specifically trained for it? — *A named role, trained for the function, not whoever happens to be available.*

Evidence: Role and training record

COMMON REASONS FOR A PARTIAL ANSWER

- **Second checks happen for the most obviously high-risk medications but not a complete list.** — A narrower list than the facility's actual high-risk medications leaves real gaps.
- **The second check exists but isn't genuinely independent — same effective judgement twice.** — Independent verification requires a second person forming their own judgement.
- **Legibility is good for handwritten scripts but electronic entries have unclear abbreviations.**

IMPLEMENTATION PLAN

When	What
Week 1	Review a sample of prescriptions for legibility and second-check evidence.
Week 2	Define the facility's specific high-risk medication list.

When	What
Week 3	Name and train a specific person or role for the second-check function.
Ongoing	Audit second-check genuineness periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Prescription legibility review	Reviews a sample of prescriptions for legibility and completeness.
DOCUMENT	Second-check record review	Reviews evidence of a genuine, independent second check for high-risk medications.
ASK	Second-check role interview	Asks who performs the second check and confirms specific training for the role.

SUPERVISOR TIPS

- **Ask who performs the second check, by name and role.** — A facility without a clinical pharmacist can still meet this fully if the function is genuinely owned by someone else.
- **Check for genuine independence, not sequential confirmation by the same judgement.** — A real second check reveals itself in a specific, separate example.

EVIDENCE BASE

[20] World Health Organization. Medication without harm: WHO global patient safety challenge. Geneva: WHO; 2017.

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4.6 Patient Identified Correctly at Every Point of Contact

NON-NEGOTIABLE

Every patient is verified using at least two identifiers before any medication, procedure, or specimen collection — applied consistently, not concentrated in one department.

In plain terms: Before any medication, procedure, blood product, or specimen — every time — staff check two identifiers against the patient's wristband.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Wrong-patient errors happen in the most ordinary moments: two patients with the same surname on one treatment area, a bed swap not updated on the board, a nurse who 'knows' the patient. The two-identifier check — name and date of birth, or name and clinic number, read from the wristband not the bed board — is the barrier. It must happen at every intervention, not just the ones staff consider high-risk, because the wrong routine medication is still the wrong medication. The wristband must exist and be legible; a clinic where a third of patients have no wristband has no identification system.

WHAT GOOD LOOKS LIKE

- Two identifiers are checked before every medication, procedure, and specimen collection.
- Staff clearly state room or slot numbers are never acceptable alone.
- Identification is consistent across every point of contact.

COMMON FAILURE MODES

- Two-identifier checking happens in one department but not consistently elsewhere.
- Room or slot numbers are used as a de facto identifier.
- Identification is treated as a one-time check for the whole visit.

WORKED EXAMPLE

IN PRACTICE

A 16-room clinic where identification was by bed number and the name on the board.

BEFORE	The Coordinator walked the treatment areas: 30% of patients had no wristband. Two patients with the surname Mammadov were in adjacent beds. Nurses identified patients by asking 'Are you Mr Mammadov?' — a leading question answered yes by either. Medications were checked against the bed board.
ACTION	Wristbands became mandatory at registration, replaced immediately if removed. The identification rule was written: ask the patient to state their name and date of birth (not confirm it), check both against the wristband, then against the prescription or request. Bed boards were removed as an identification source. Same-name alerts were added to the treatment area board.
AFTER	The Monitor found wristbands on 100% of patients across three treatment areas. Observed six medication rounds: identification done correctly in all. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk one treatment area and count patients without a wristband.
2. Watch a medication round: how does the nurse identify each patient?
3. Write the rule: two identifiers, from the wristband, stated by the patient, before every intervention.
4. Make wristbands a non-negotiable at registration.

The most common mistake: Asking 'Are you Mr X?' — a confused, deaf, or polite patient will say yes to anything.

SELF-ASSESSMENT QUESTIONS

1. Are two identifiers checked before every medication, procedure, and specimen collection? — *Applied consistently across every point of contact, not just one.*

Evidence: Identification protocol

2. Is a room or appointment slot number ever used as an identifier?

— *These change and are never acceptable as an identifier alone.*

Evidence: N/A — tested directly

3. Is identification checked independently at each new point of

contact? — *Not relying on identification done earlier in the same visit.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The practice is strong where introduced first but hasn't spread clinic-wide.** — A safety practice introduced for one purpose sometimes doesn't generalise without deliberate effort.
- **Staff verify identity but use a mix of acceptable and unacceptable identifiers.** — Partial adherence can be harder to catch than complete absence.
- **Verification happens at check-in and is assumed to carry through the visit.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit identification practice across all points of contact.
Week 2	Brief all staff that room or slot numbers are never acceptable alone.
Week 3	Extend consistent identification practice clinic-wide.
Ongoing	Spot-check identification practice across different service points.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Identification practice observation	Observes identification practice at multiple points of contact during a visit.
ASK	Staff practice interview	Asks staff what counts as an acceptable identifier.
DOCUMENT	Cross-point consistency review	Reviews identification practice across different service points for consistency.

SUPERVISOR TIPS

- **Observe a full visit sequence, not just one department.** — This is where the practice most commonly fails to generalise.
- **Ask specifically whether room or slot numbers are ever used.** — A direct question often reveals what a general policy question won't.

EVIDENCE BASE

[21] Joint Commission International. International patient safety goals. 7th ed. Oak Brook (IL): JCI; 2020.

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4.7 A Defined, Working Referral Relationship With a Named Receiving Facility

NON-NEGOTIABLE

The clinic has a specific, working relationship with a named facility able to receive patients needing care beyond this clinic's own capacity — not a general assumption that somewhere will take the patient if needed.

In plain terms: The clinic has a named hospital or specialist it sends patients to when they need more than the clinic can provide — with a working phone number and an agreed process.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Every clinic sees patients it cannot manage: the chest pain that might be a heart attack, the child with a fracture, the pregnancy with bleeding. What happens next depends entirely on whether the clinic has a real relationship with somewhere that will take them — a number that is answered, a named contact, an agreed way to hand over. Without it, the patient is told to 'go to the hospital' and left to find their

own way, or the clinic phones around while the patient deteriorates. A named receiving facility with a tested pathway turns a crisis into a process.

WHAT GOOD LOOKS LIKE

- A specific, named receiving facility relationship exists and is genuinely used.
- A recent, real example demonstrates the relationship works in practice.
- Staff describe the referral process immediately and confidently.

COMMON FAILURE MODES

- No specific facility is named; referral is a general assumption.
- The relationship exists on paper but has never actually been used.
- Staff are uncertain about the referral process.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic 20 km from the nearest hospital, with no formal referral agreement.

BEFORE

When a patient needed hospital care, the doctor phoned the hospital switchboard and was transferred repeatedly. Referral letters were handwritten and often lost. There was no way to know whether the patient had arrived or been seen. A patient with suspected appendicitis was sent by taxi with a letter; the hospital had no record of receiving her.

ACTION

The clinic director met the hospital's medical director and agreed a referral pathway: a direct line to the emergency department triage nurse, a standard referral form (faxed or emailed ahead), an ambulance arrangement for unstable patients, and a monthly feedback call. The agreement was written and signed. The number was posted in every consulting room.

AFTER

The Monitor reviewed the signed agreement, the referral form, and a log of 15 referrals with

hospital confirmation of receipt. Phoned the direct line during the visit; it was answered by triage. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Name the facility you send emergencies to. Now phone them — who answers, and how long does it take?
2. Meet their emergency department lead and agree a direct number and a referral form.
3. Write it down and sign it.
4. Post the number in every room.

The most common mistake: Assuming the hospital will take your patients because it always has — without a named contact, every referral is a cold call.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, named receiving facility for cases beyond this clinic's capacity? — *A specific name and working relationship, not a general assumption.*

Evidence: Referral agreement or relationship record

2. Has this relationship been used and does it actually work in practice? — *A theoretical relationship and a genuinely functioning one are different things.*

Evidence: Recent referral example

3. Do staff know the specific process for making this referral, without hesitation? — *Genuine, immediate familiarity, not something staff have to figure out under pressure.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A relationship exists for the most common referral need but not less frequent ones.** — Coverage often concentrates on the most visible need.
- **The relationship worked once, historically, but hasn't been confirmed as still active.** — Relationships can lapse without anyone at either end noticing.
- **Staff know the process exists but not the specific steps.**

IMPLEMENTATION PLAN

When	What
Week 1	Identify the most likely referral needs beyond this clinic's capacity.
Week 2	Establish or confirm a specific, named receiving facility relationship for each.
Week 3	Brief all staff on the specific referral process.
Ongoing	Confirm the relationship remains active periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Referral relationship review	Reviews evidence of a specific, named receiving facility relationship.
DOCUMENT	Recent use review	Reviews a recent example of the referral relationship actually being used.
ASK	Staff process interview	Asks staff to describe the referral process without hesitation.

SUPERVISOR TIPS

- **Ask for a real, recent referral example, not a description of the relationship.** — A real example reveals whether this genuinely functions.
- **Ask a staff member to describe the process without prompting.** — Immediate, confident recall reveals genuine operational readiness.

EVIDENCE BASE

[22] Continuity of care across facility transitions is identified in cross-border and ambulatory healthcare literature as a distinct risk point, with informal or undefined referral relationships directly linked to preventable delays in care.

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4.8 Referral Follow-Through Is Confirmed, Not Assumed

NON-NEGOTIABLE

When a patient is referred elsewhere, the clinic confirms the patient actually reached and was seen by the receiving facility — not assumed from the referral having been made.

In plain terms: When you refer a patient somewhere, you check that they actually got there and were seen — you do not assume it from having written the letter.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Referral letters get lost. Patients do not go — they cannot afford it, cannot get transport, are afraid, or do not understand the urgency. The receiving facility does not have the appointment. In each case, the clinic believes the patient is being looked after, and the patient believes the clinic knows they are not. A cancer referral that never arrives is a death sentence delivered by administrative failure. Confirmation means a phone call, a return form, or a system message that says: this patient was seen on this date. Without it, the referral is a hope.

WHAT GOOD LOOKS LIKE

- A specific process actively confirms referral completion.
- A defined action follows when a referral isn't confirmed.
- Follow-through is tracked as a specific, reviewed metric.

COMMON FAILURE MODES

- No process exists beyond assuming the referral was completed.
- No action follows when a patient doesn't confirm as having gone.
- Follow-through is not tracked at all.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic referring 40–50 patients a month to hospitals and specialists.

BEFORE	Referrals were made by letter given to the patient. There was no log. When the Coordinator sampled 30 referrals from three months earlier and phoned the receiving facilities, 11 had no record of the patient. Three of those were urgent referrals for suspected cancer. Nobody at the clinic had known.
ACTION	A referral log was created: date, patient, destination, urgency, expected appointment. Urgent referrals are phoned through with a confirmation call scheduled at 7 days. Routine referrals are checked at 30 days. Any patient not seen is contacted and the referral repeated or escalated. The log is reviewed weekly.
AFTER	The Monitor reviewed the log: 120 referrals in three months, 94% confirmed seen, 7 patients recovered who had not attended and were re-referred. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Take your last 20 referrals and phone the receiving facility: was the patient seen?
2. Start a referral log with a confirmation column.
3. Phone-confirm every urgent referral within 7 days.
4. Check routine referrals at 30 days and chase any not seen.

The most common mistake: Treating the referral letter as the end of your responsibility — it is the beginning of a process you must close.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific process to confirm a referred patient actually reached the receiving facility? — *Active confirmation, not an assumption the referral was completed.*
Evidence: Referral follow-through record

2. Is there a defined action if a patient does not confirm as having reached the referral? — *Detecting a gap without acting on it provides no real protection.*

Evidence: Non-completion response protocol

3. Is follow-through tracked as a specific, reviewed metric? — *Untracked follow-through cannot be improved or verified as working.*

Evidence: Follow-through tracking record

COMMON REASONS FOR A PARTIAL ANSWER

- **Confirmation happens for urgent referrals but not routine ones.** — Routine referrals can still represent a genuine, missed diagnosis risk.
- **A non-completion is noticed but no specific action follows.** — Noticing without acting provides limited real protection.
- **Tracking exists but isn't regularly reviewed for patterns.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent referrals for evidence of completion confirmation.
Week 2	Establish a specific confirmation process for all referrals, not only urgent ones.
Week 3	Define a specific action for unconfirmed referrals.
Ongoing	Review follow-through tracking data periodically for patterns.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Follow-through record review	Reviews evidence of active confirmation that referred patients reached the receiving facility.
DOCUMENT	Non-completion response review	Reviews the defined action taken when a referral isn't confirmed as completed.
ASK	Tracking metric interview	Asks staff how referral follow-through is tracked and reviewed.

SUPERVISOR TIPS

- **Ask for a real example of a referral that wasn't completed and what happened next.** — A real example, or its honest absence, reveals whether this system functions.
- **Check routine referrals specifically, not just urgent ones.** — Routine-seeming referrals are where follow-through most commonly lapses.

EVIDENCE BASE

[23] Unreconciled specialist referrals are identified as a contributing factor in a substantial share of ambulatory diagnostic-error malpractice claims, distinct from the referral decision itself.

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4.9 **Every Test Result Reaches the Patient, Abnormal or Not**

NON-NEGOTIABLE

Every laboratory or imaging result is actively communicated back to the patient through a specific, tracked process, with abnormal results reaching them faster, not slower — not left in a chart assumed to have been seen.

In plain terms: Every test result — normal or abnormal — is actively communicated to the patient, and abnormal results reach them faster, not slower.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

'No news is good news' has killed patients. The abnormal result filed in the chart, the biopsy report that arrived when the doctor was on leave, the raised PSA nobody phoned about — each is a diagnosis delayed by months because the clinic assumed the patient would call, or the doctor would remember, or the result would 'come up' at the next visit.

A working result system tracks every test from order to communication: what was ordered, whether it came back, whether it was reviewed, whether the patient was told. Abnormal results have a shorter clock. The patient is told, not left to ask.

WHAT GOOD LOOKS LIKE

- A specific, tracked process ensures every result reaches the patient.
- Abnormal results follow a genuinely faster, specific pathway.
- The system can identify and surface an uncommunicated result.

COMMON FAILURE MODES

- Results are filed with no active communication process.
- Abnormal results receive no faster treatment than routine ones.
- There is no way to identify a result that fell through the cracks.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic ordering 300 tests a month with results returned by email and paper.

BEFORE

Results arrived and were filed in patient charts, to be seen at the next visit. Nobody tracked whether a result had come back. The Coordinator found a mammogram report showing a suspicious mass, filed for four months, never acted on — the patient had not returned. Two other abnormal results had similar histories.

ACTION

A results tracking system was introduced: every test ordered is logged; the log is checked daily for results not returned within the expected time; every result is reviewed by a clinician within 48 hours; abnormal results trigger a phone call within 24 hours; normal results are communicated by the method the patient chose at ordering. The Coordinator audited the log weekly.

AFTER

The Monitor reviewed three months of the log: all tests tracked, 99% of results reviewed within 48 hours, all abnormal results phoned within 24 hours. The

mammogram patient had been recalled and treated. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 30 test results from three months ago. For each, can you show the patient was told?
2. Start a log of every test ordered with an expected return date.
3. Assign one person to check the log daily for results not returned.
4. Rule: abnormal results phoned within 24 hours; normal results communicated within a week.

The most common mistake: Relying on the patient's next visit to review results — the patient with the abnormal result may never come back.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, tracked process ensuring every test result reaches the patient? — *A specific, named process, not an assumption results will be seen and acted on.*

Evidence: Result communication process

2. Do abnormal results reach the patient faster than normal ones, by design? — *A specific, faster pathway for abnormal results, not the same speed for everything.*

Evidence: Abnormal result pathway

3. Is there a way to identify a result that was never actually communicated? — *A tracking mechanism that surfaces a gap, not one that only shows completed communications.*

Evidence: Uncommunicated result tracking

COMMON REASONS FOR A PARTIAL ANSWER

- **Communication happens reliably for results reviewed by the ordering clinician personally, but not for others covering.** — Coverage transitions are exactly where results can fall through unnoticed.
- **An abnormal-result pathway exists but relies on someone manually noticing the abnormal flag.** — Manual reliance without a systematic prompt can miss results under time pressure.
- **Tracking exists but nobody reviews it to look for gaps.**

IMPLEMENTATION PLAN

When	What
Week 1	Review a sample of recent results for evidence of actual patient communication.
Week 2	Establish a specific, faster pathway for abnormal results.
Week 3	Build a tracking mechanism that surfaces uncommunicated results.
Ongoing	Review the tracking system periodically for any gap.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Result communication process review	Reviews the specific process ensuring results reach patients.
DOCUMENT	Abnormal result pathway review	Reviews whether abnormal results follow a specifically faster pathway.
OBSERVE	Uncommunicated result check	Checks whether the tracking system can actually surface a result that was never communicated.

SUPERVISOR TIPS

- **Ask for a real, recent example and trace whether the patient actually received the result.** — A real example reveals whether this is genuine practice or assumed.
- **Ask specifically about coverage situations — a different clinician handling a colleague's results.** — This is where the process most commonly breaks down.

EVIDENCE BASE

[24] Callen JL, Westbrook JI, Georgiou A, Li J. Failure to follow-up test results for ambulatory patients: a systematic review. J Gen Intern Med. 2011;27(10):1334-1348 — found 6.8% to 62% of laboratory results and up to 36% of radiology results in ambulatory care settings were never followed up.

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4.10 A Chaperone Is Genuinely Offered for Every Sensitive Examination

NON-NEGOTIABLE

Every patient undergoing a genital, pelvic, rectal, or breast examination, or any examination they consider sensitive, is offered a trained chaperone — not assumed comfortable without one, and not left with a chaperone who is only an untrained bystander.

In plain terms: Every patient having an intimate or sensitive examination is offered a trained chaperone — and the offer, and the answer, are recorded.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

A chaperone protects the patient from abuse and the clinician from allegation. A patient undergoing a pelvic, breast, genital, or rectal examination is in a position of extreme vulnerability; a chaperone in the room is a witness and a comfort. The offer must be genuine — not a mumbled question the patient is expected to decline — and the chaperone must be trained: knowing where to stand, what to observe, and what to do if something is wrong. The patient may decline; that is their right. But the offer must be made, and the record must show it. A clinic that does not offer chaperones has decided to trust every clinician absolutely.

WHAT GOOD LOOKS LIKE

- A trained chaperone is genuinely offered before every sensitive examination.
- Chaperones are trained staff, not the patient's own

COMMON FAILURE MODES

- Chaperones are offered inconsistently, only when a patient happens to ask.
- A patient's own family member is treated as an adequate substitute.

- companion.
- A patient's decision to decline is respected and recorded.

- Declining a chaperone isn't genuinely respected or documented.

WORKED EXAMPLE

IN PRACTICE

A 10-room clinic with two male physicians seeing female patients for gynaecological and breast examinations.

BEFORE

Chaperones were not offered. Patients who asked were told 'the nurse is busy.' A complaint had been received from a patient who felt uncomfortable during a breast examination with no one else present. There was no chaperone policy and no trained chaperones.

ACTION

A chaperone policy was written: offered for every intimate examination, verbally and on a sign in each consulting room; three nursing staff completed a half-day chaperone training; the offer and the patient's response are recorded on the consultation note; if declined, the clinician may also decline to proceed and rebook with a chaperone.

AFTER

The Monitor reviewed 25 consultation notes with intimate examinations: all showed the offer and response. Observed a sign in each room. Interviewed a trained chaperone who described her role. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask your clinicians: do you offer a chaperone for intimate examinations? Every time?
2. Write a one-page policy and put a sign in every consulting room.
3. Train three staff as chaperones — half a day.
4. Add 'chaperone offered: Y/N; accepted: Y/N' to the consultation note.

The most common mistake: Offering a chaperone only when the patient asks — the patients most at risk are the ones least likely to ask.

SELF-ASSESSMENT QUESTIONS

1. Is a trained chaperone genuinely offered before every sensitive examination? — *Offered as standard practice, not only when a patient happens to ask.*

Evidence: Chaperone offer documentation

2. Is the chaperone a trained staff member, not a patient's own companion? — *A friend or family member is not a substitute for a trained chaperone.*

Evidence: Chaperone training record

3. Is a patient's decision to decline the chaperone genuinely respected and recorded? — *The patient's right to decline is real, not a formality.*

Evidence: Decline documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Chaperones are offered for gynaecological exams but not consistently for other sensitive exams.** — Sensitivity extends beyond one specific examination type, per the patient's own perception.
- **A chaperone is present but was never specifically trained for the role.** — An untrained bystander doesn't provide the same genuine safeguard.
- **The offer happens but is made so casually that patients don't feel it's a genuine option.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current chaperone offer practice across all relevant examination types.
Week 2	Train designated staff specifically for the chaperone role.
Week 3	Standardise how the offer is made so it feels like a genuine choice.
Ongoing	Audit chaperone offer documentation periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Chaperone offer review	Reviews documentation for consistent chaperone offers before sensitive examinations.
DOCUMENT	Chaperone training review	Reviews training records for staff serving as chaperones.
ASK	Patient experience interview	Asks a patient whether a chaperone was genuinely offered for a relevant examination.

SUPERVISOR TIPS

- **Ask a patient directly whether a chaperone was offered, not just whether one was present.** — This reveals whether the offer was genuine, not just whether someone happened to be in the room.
- **Check chaperone training records specifically, not just presence in the room.** — An untrained bystander doesn't meet this standard even if physically present.

EVIDENCE BASE

[25] Established international medical ethics guidance recognizes the offer of a trained chaperone for sensitive examinations as a formal professional standard, irrespective of the gender of the clinician or patient, reflected in professional body guidance across many countries.

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4.11 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 — verified through observation and patient experience, not assumed from a written policy.

In plain terms: Every patient is treated with dignity regardless of who they are, and you can show that care decisions are not affected by race, religion, gender, disability, wealth, or any other status.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Discrimination in healthcare is rarely a policy; it is a hundred small decisions — who waits longer, who gets the private room, whose pain is believed, whose questions are answered. It is often invisible to the people who work in the system and painfully visible to those on the receiving end. The standard asks for more than a non-discrimination statement: it asks for evidence — patient feedback disaggregated by group, complaints reviewed for patterns, staff who can describe what dignified care looks like in practice, and a way for a patient who feels discriminated against to say so and be heard.

WHAT GOOD LOOKS LIKE

- A policy specifically covers clinical care decisions.
- Staff describe concrete, specific practices.
- A discrimination-specific reporting mechanism exists.

COMMON FAILURE MODES

- Policy exists only for employment matters.
- Staff can only offer general assurances.
- No distinct mechanism exists for reporting discrimination.

WORKED EXAMPLE

IN PRACTICE

A 14-room clinic serving a city with a significant minority-language population.

BEFORE	A non-discrimination policy existed. Patient surveys were not broken down by any group. The Coordinator reviewed complaints: three in the past year alleged discriminatory treatment; all were closed as 'no evidence.' Minority-language patients waited longer at registration because staff did not speak their language and no interpreter was arranged.
ACTION	Patient experience surveys were disaggregated by language, age, and gender. A dignity and respect module was added to induction, with concrete examples. Complaints alleging discrimination were routed to a named senior person with a defined investigation. Interpreter access was arranged (see 8.3/9.3). Waiting-time data by language group was reviewed quarterly.
AFTER	The Monitor reviewed disaggregated survey data showing waiting-time equity within 10%. Interviewed four staff who described dignity practices concretely. Reviewed a discrimination complaint investigated in full. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Break your patient survey down by language, gender, and age — are the results the same?
2. Review any complaint alleging discrimination in the last two years — how was it investigated?
3. Ask five staff to describe one specific thing that shows dignity in care.
4. Create a route for discrimination complaints to a named senior person.

The most common mistake: Having a non-discrimination policy and no data — you cannot demonstrate equity you have never measured.

SELF-ASSESSMENT QUESTIONS

1. Is there a written non-discrimination policy covering care decisions specifically? — *Covering clinical care, not just a general workplace policy.*

Evidence: Non-discrimination policy document

2. Can staff describe specific ways they ensure equitable treatment? — *Concrete practices, not a general assurance.*

Evidence: N/A — tested directly

3. Is there a mechanism to report perceived discriminatory treatment specifically? — *A pathway that names discrimination directly, not folded anonymously into general feedback.*

Evidence: Discrimination-specific reporting mechanism

COMMON REASONS FOR A PARTIAL ANSWER

- **Policy exists but was never specifically communicated to clinical staff.** — A policy that never reaches decision-makers has limited practical effect.
- **Staff describe good intentions but struggle with specific examples.** — Genuine practice usually shows in specific examples.
- **A reporting mechanism exists but few patients know it's available.**

IMPLEMENTATION PLAN

When	What
Week 1	Review policy scope for coverage of clinical care decisions.
Week 2	Communicate the policy directly to clinical staff with concrete examples.
Week 3	Establish a distinct, communicated discrimination reporting mechanism.
Ongoing	Gather patient feedback periodically on equitable treatment.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Policy scope review	Reviews the policy for coverage of clinical care decisions specifically.

Method	What	Detail
ASK	Staff practice interview	Asks staff to describe specific, concrete practices ensuring equitable treatment.
OBSERVE	Patient experience check	Where possible, gathers patient feedback on whether treatment felt equitable.

SUPERVISOR TIPS

- **Ask staff for a specific example, not a general assurance.** — Concrete examples distinguish genuine internalisation from stated policy.
- **Ask how a patient would report a discrimination concern specifically.** — A distinct, known pathway is the real evidence.

EVIDENCE BASE

[26] Non-discrimination and equitable treatment are foundational patient rights principles across international healthcare quality frameworks, consistently requiring verification through actual patient experience and observed practice.

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4.12 Reusable Equipment Is Cleaned and Sterilised Between Patients

NON-NEGOTIABLE

All reusable equipment is cleaned and, where required, sterilised between every patient use, following a defined process, verified, not assumed from general good practice.

In plain terms: Reusable instruments and equipment are cleaned and sterilised between every patient using a defined, verified process — not just wiped down.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A speculum, a pair of forceps, an otoscope tip, a nebuliser mask — each carries the last patient's organisms to the next unless it is properly reprocessed. In a clinic without a central sterile service, this falls to whoever is available, using whatever method seems reasonable. That is how hepatitis B and C are transmitted in outpatient settings. A defined process means: what gets cleaned how, what gets sterilised (and by which method), who does it, how it is verified (indicator strips, autoclave logs), and where clean and dirty are kept apart. Wiping with alcohol is not sterilisation.

WHAT GOOD LOOKS LIKE

- A defined process exists and is followed for every reusable equipment type.
- Completion is genuinely verified for every use.
- Equipment with uncertain reprocessing is removed from use.

COMMON FAILURE MODES

- No defined process exists beyond general good practice.
- Completion is assumed from habit, never actually verified.
- Equipment with uncertain status continues to be used.

WORKED EXAMPLE

IN PRACTICE

A 12-room clinic with a benchtop autoclave and reusable specula, instruments, and ENT equipment.

BEFORE

Instruments were rinsed and put in the autoclave 'when there were enough.' The autoclave had no log and no indicator use. Specula were sometimes wiped with alcohol and reused between patients on busy days. Clean and dirty instruments were on the same shelf. Staff had no written process.

ACTION

A reprocessing process was written and posted: pre-clean → wash → dry → package with indicator → autoclave with cycle log → store in clean area. Chemical indicators were placed in every package; a biological indicator was run weekly. Dirty and clean areas were physically separated. One nurse was designated as

responsible and trained. Single-use specula were adopted for high-volume days.

AFTER

The Monitor reviewed six weeks of autoclave logs with indicator results, observed separated clean/dirty areas, and watched a reprocessing cycle. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every reusable item that touches a patient.
2. For each, write down: clean only, or sterilise? By what method?
3. Check your autoclave has a log and that you use indicators.
4. Separate clean and dirty storage physically.

The most common mistake: Wiping instruments with alcohol between patients on busy days — alcohol does not sterilise.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined cleaning and sterilisation process for every reusable equipment type? — *A specific process per equipment type, not a general cleaning routine.*

Evidence: Reprocessing protocol

2. Is completion of the process verified for every use, not assumed from staff following habit? — *A verification step, not reliance on memory alone.*

Evidence: Verification record or indicator

3. Is equipment that cannot be verified as properly reprocessed removed from use? — *Uncertainty should result in removal, not continued use assuming it's fine.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A process exists for the most obviously invasive equipment but not all reusable items.** — Attention concentrates on the most visible risk, missing less obvious equipment.
- **Verification happens but isn't documented, relying on staff memory.** — Undocumented verification is hard to distinguish from assumed completion.

- **Staff are uncertain what to do if reprocessing status is unclear for an item.**

IMPLEMENTATION PLAN

When	What
Week 1	Inventory all reusable equipment and current reprocessing practice.
Week 2	Establish a defined, documented process for every equipment type.
Week 3	Build a verification step into the standard workflow.
Ongoing	Audit reprocessing documentation periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Reprocessing protocol review	Reviews the defined process for each reusable equipment type.
OBSERVE	Verification step check	Checks whether completion is genuinely verified, not assumed.
ASK	Uncertainty handling interview	Asks staff what happens if reprocessing completion is uncertain for a specific item.

SUPERVISOR TIPS

- **Ask for the verification record for a specific piece of equipment.**
— A specific, documented example is the real evidence of genuine practice.
- **Ask what happens when reprocessing status is uncertain.** — A confident, specific answer reveals whether this is genuinely handled or left to chance.

EVIDENCE BASE

[27] Standard and transmission-based precautions frameworks identify verified reprocessing of reusable equipment as a distinct, essential infection prevention control, separate from general environmental cleanliness.

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← Ambulatory Clinic
Standards — all standards

Self-assess against these
criteria →

← Standard 3 —
Environment & Shared
Spaces

Standard 5 — Safety &
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