

ASF STANDARDS · AMBULATORY · STANDARD 27

Standard 27 — Sustainable Care

7 criteria · 2 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 6, 6th Edition

CRITERIA IN THIS STANDARD

- 27.1 — Environmental Impact Is Genuinely Assessed, Not Assumed Negligible
- 27.2 — Clinical Waste Is Genuinely Segregated and Responsibly Disposed
- 27.3 — Procurement Genuinely Considers Environmental Impact
- 27.4 — Energy and Resource Use Are Genuinely Monitored and Reduced Where Possible
- 27.5 — Patients and Staff Are Genuinely Engaged in Sustainability Practice
- 27.6 — The Clinic Genuinely Plans for Climate-Related Operational Risk
- 27.7 — Sustainability Commitments Are Genuinely Reviewed, Not Static

27.1

Environmental Impact Is Genuinely Assessed, Not Assumed Negligible

STANDARD

The clinic genuinely assesses its environmental impact — energy use, waste generation, water consumption — rather than assuming its small footprint compared to a hospital makes real assessment unnecessary.

In plain terms: The clinic has actually looked at its own real environmental footprint — not just assumed that being small means it doesn't need to check.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A single ambulatory clinic's environmental footprint is genuinely smaller than a hospital's, but "smaller" is not the same as "negligible" or "not worth assessing" — and the assumption that small size exempts a facility from real environmental accountability is itself the problem. With hundreds of ambulatory clinics operating within a health system, their combined genuine impact is significant even when any one facility's footprint looks modest in isolation. A real, if proportionate, assessment is what distinguishes genuine environmental responsibility from an assumption resting on relative scale.

WHAT GOOD LOOKS LIKE

- The clinic has genuinely assessed its own environmental impact, appropriately scaled to its size.
- The assessment genuinely covers energy, waste, and water, not a single easy metric.
- The assessment is genuinely revisited periodically, not conducted once and forgotten.

COMMON FAILURE MODES

- No assessment has ever been conducted, justified by the clinic's small size.
- Only one easy-to-measure dimension, like electricity cost, is tracked as if representative.
- A single assessment from years ago is treated as still current.

WORKED EXAMPLE

IN PRACTICE

A 12-provider ambulatory clinic with no prior environmental review.

BEFORE

Nobody at the clinic had ever formally looked at its energy use, waste volume, or water consumption — these were simply operating costs paid monthly, with no one examining what

they actually represented or whether they could be reduced.	
ACTION	A simple, proportionate self-assessment was conducted using utility bills and waste collection records from the past year, giving the clinic its first real baseline figures across all three dimensions.
AFTER	The Monitor reviewed the baseline assessment document and confirmed it covered energy, waste, and water with real, specific figures rather than estimates. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull the last 12 months of utility bills and waste collection invoices.
2. Compile a simple one-page baseline covering energy, waste, and water.
3. Set a date to revisit this baseline annually.

The most common mistake: Treating clinic size as a reason real assessment isn't worth doing, rather than simply a reason to scale the assessment proportionately.

SELF-ASSESSMENT QUESTIONS

1. Has the clinic genuinely assessed its own environmental impact, not assumed its small size makes this unnecessary? — *A real, documented assessment, not an assumption based purely on facility size.*
Evidence: Environmental baseline assessment document
2. Does this assessment genuinely cover energy, waste, and water, not a single dimension treated as representative? — *Real, multi-dimensional coverage, not one easy metric standing in for the whole picture.*
Evidence: Multi-dimensional assessment data
3. Is the assessment genuinely revisited periodically, not conducted once and left unexamined? — *Real, periodic review, not a static*

COMMON REASONS FOR A PARTIAL ANSWER

- **Energy use is tracked but waste and water are not.** — A genuinely complete picture requires all three dimensions, not the easiest one alone.
- **An assessment was done once at opening but never repeated since.** — A clinic's operations and impact change over time; a static baseline grows stale.

IMPLEMENTATION PLAN

When	What
Week 1	Gather 12 months of utility and waste data.
Week 2	Compile a baseline document covering all three dimensions.
Annually	Revisit and update the baseline.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Baseline review	Reviews the environmental baseline for genuine, multi-dimensional coverage.

SUPERVISOR TIPS

- **Ask to see actual figures, not a general statement that the clinic is “environmentally conscious.”** — Specific figures distinguish a genuine assessment from a vague intention.

EVIDENCE BASE

World Health Organization. WHO Guidance for Climate-Resilient and Environmentally Sustainable Health Care Facilities. Geneva: WHO; 2020.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

27.2

Clinical Waste Is Genuinely Segregated and Responsibly Disposed

STANDARD

Clinical and hazardous waste is genuinely segregated from general waste at the point of generation and disposed of through a responsible, verified pathway — not mixed waste streams justified by the clinic’s smaller volume compared to a hospital.

In plain terms: Medical waste is actually kept separate from regular trash, right from the moment it’s generated, and goes somewhere genuinely responsible — not mixed together because the clinic doesn’t produce as much as a hospital.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Lower volume does not change the genuine hazard properties of clinical waste — sharps, contaminated materials, and pharmaceutical waste carry real risk regardless of how much of it a facility produces, and improper disposal creates genuine environmental and public health risk whether it comes from a hospital or a single exam room. A clinic that relaxes segregation discipline because “we don’t generate much” is applying a volume-based justification to a hazard that doesn’t actually scale down that way.

WHAT GOOD LOOKS LIKE

- Clinical waste is genuinely segregated at every point of generation.
- The disposal pathway is genuinely verified, not assumed compliant.
- Staff are genuinely trained with real, observable compliance.

COMMON FAILURE MODES

- Sharps or contaminated materials occasionally go into general waste under time pressure.
- A waste contractor is engaged but never actually verified as compliant.
- Segregation rules exist on a poster but aren’t

WORKED EXAMPLE

IN PRACTICE

A clinic relying on informal waste segregation practices.

BEFORE

Sharps bins were available but general waste bins were sometimes used for contaminated dressings during busy periods, and the clinic had never actually verified where its contracted waste disposal company took the clinical waste.

ACTION

Clearly labeled, conveniently placed segregation bins were installed in every exam room, a brief refresher was delivered to all staff, and the disposal contractor's licence and final disposal site were directly verified and documented.

AFTER

The Monitor observed correctly segregated bins during a walkthrough and reviewed the documented verification of the disposal contractor's licence. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check every exam room has clearly labeled, conveniently placed segregation bins.
2. Directly verify your waste contractor's licence and disposal pathway, don't just assume it.
3. Brief all staff on correct segregation practice.

The most common mistake: Assuming a contracted waste disposal company is compliant without ever directly verifying its licence or actual disposal pathway.

SELF-ASSESSMENT QUESTIONS

1. Is clinical waste genuinely segregated from general waste at every point of generation? — *Real, consistent segregation, not a*

2. Is the disposal pathway for clinical waste genuinely verified? — A real, verified pathway, not an assumption resting solely on a vendor's claims.

Evidence: Contractor licence verification record

3. Are staff genuinely trained in correct segregation, with real, observable compliance? — Real, demonstrated staff practice, not rules that exist only on a poster.

Evidence: Training record, observed compliance

COMMON REASONS FOR A PARTIAL ANSWER

- **Segregation is good in theory but lapses during busy periods.**
— Genuine, consistent practice should hold up under real operational pressure.
- **A contractor is used but its disposal pathway has never actually been verified.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit and correct bin placement and labeling across all exam rooms.
Week 2	Verify the waste contractor's licence and disposal pathway directly.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Direct observation	Observes segregation practice during a walkthrough of exam rooms.
DOCUMENT	Contractor verification	Reviews documented verification of the disposal contractor's licence.

SUPERVISOR TIPS

- **Check a bin at random during a busy period, not just at a quiet moment.** — Genuine compliance holds under real pressure, not just when things are calm.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

27.3

Procurement Genuinely Considers Environmental Impact

CORE

Procurement decisions genuinely factor in environmental impact alongside cost and clinical suitability — not sustainability treated as an afterthought with purchasing decided purely on price.

In plain terms: When the clinic buys supplies, it actually thinks about environmental impact as one real factor — not purely the cheapest option every time, with sustainability never actually weighed in.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Procurement decisions compound across every purchase cycle, and a clinic that never factors environmental impact into these decisions is, in effect, systematically optimizing away from sustainability on every order — not through any single bad decision, but through the consistent absence of the consideration entirely. This is marked Core because genuine sustainability commitment is tested precisely at the point of actual spending decisions, not in policy statements; a clinic can claim sustainability values while every real purchasing choice ignores them entirely.

WHAT GOOD LOOKS LIKE

- Procurement genuinely weighs environmental impact alongside cost and clinical need.

COMMON FAILURE MODES

- Purchasing decisions are made purely on price, with environmental impact never actually discussed.

- A real, documented instance shows environmental considerations genuinely influencing a purchase.
- Single-use consumables are genuinely reviewed for lower-impact alternatives.

- A sustainability policy exists but has never genuinely changed a single purchasing decision.
- Single-use defaults are never reviewed, even where safe alternatives exist.

WORKED EXAMPLE

IN PRACTICE

A clinic reviewing its supply ordering practices.

BEFORE	Supply orders were placed by whoever had time, chosen purely on unit price with no consideration of packaging waste, supplier sustainability credentials, or reusable alternatives where clinically appropriate.
ACTION	A simple environmental consideration was added to the supply reorder checklist, and a reusable alternative was identified and adopted for one previously single-use, non-critical item, with the decision documented.
AFTER	The Monitor reviewed the updated checklist and the documented decision to switch to a reusable alternative. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add an environmental consideration line to your supply reordering checklist.
2. Identify one non-critical, single-use item with a viable reusable alternative.
3. Document the first real decision made with environmental impact considered.

The most common mistake: Holding a stated sustainability value that has never actually influenced a single real purchasing

SELF-ASSESSMENT QUESTIONS

1. Does procurement genuinely weigh environmental impact, not cost and clinical need alone? — *Real, documented consideration, not an unexamined, purely cost-driven decision.*

Evidence: Procurement criteria documentation

2. Is there a real, documented instance where a procurement choice was genuinely influenced by environmental considerations? — *A concrete, real example, not a policy with no actual purchasing decision behind it.*

Evidence: Specific purchasing decision record

3. Are single-use consumables genuinely reviewed for lower-impact alternatives where clinically safe? — *A real, ongoing review, not single-use defaults left unexamined indefinitely.*

Evidence: Consumables review record

COMMON REASONS FOR A PARTIAL ANSWER

- **Environmental impact is discussed informally but never actually documented as a factor.**
- **A review of single-use items happened once but hasn't become a recurring practice.**

IMPLEMENTATION PLAN

When	What
Week 1	Add environmental consideration to the procurement checklist.
Week 2-3	Review current single-use items for viable, safe reusable alternatives.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Procurement record review	Reviews a real purchasing decision for documented environmental consideration.

SUPERVISOR TIPS

- **Ask for one specific, real example, not a general statement of values.** — A concrete example is the clearest test that this genuinely

EVIDENCE BASE

NHS England. Delivering a Net Zero National Health Service. London: NHS England; 2022.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

27.4

Energy and Resource Use Are Genuinely Monitored and Reduced Where Possible

STANDARD

The clinic genuinely monitors its energy and resource consumption, pursuing real, achievable reductions appropriate to its scale — not resource use left untracked because the facility is too small to warrant real attention.

In plain terms: Someone actually watches what the clinic spends on energy and resources, and real, practical steps are taken to use less where that’s genuinely achievable — not energy bills just paid without anyone really looking at the trend.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Energy monitoring doesn't require sophisticated infrastructure — even a modest ambulatory clinic can track monthly consumption against prior periods and identify real, achievable efficiency opportunities, from LED lighting to equipment scheduling. The genuine failure here isn't lacking a hospital-scale sustainability programme; it's never actually looking at the numbers at all, which means even the simplest, cheapest improvements go unidentified and unrealized indefinitely.

WHAT GOOD LOOKS LIKE

- Energy consumption is genuinely tracked, not

COMMON FAILURE MODES

- Utility bills are paid with no one actually reviewing

- The clinic has genuinely identified and pursued at least one real efficiency improvement.
- Progress is genuinely reviewed periodically.

- No efficiency improvement has ever actually been identified or pursued.
- An improvement was made once but progress since has never been reviewed.

WORKED EXAMPLE

IN PRACTICE

A clinic that had never reviewed its own energy trends.

BEFORE	Monthly electricity bills were paid by the office manager with no one ever actually comparing month-to-month or year-to-year usage, and the clinic still used older fluorescent lighting throughout.
ACTION	A simple spreadsheet was set up to track monthly consumption, revealing a clear trend, and a phased switch to LED lighting was initiated, starting with the highest-usage areas.
AFTER	The Monitor reviewed the tracking spreadsheet showing genuine, ongoing monitoring and the documented LED conversion as a real, implemented improvement. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Set up a simple spreadsheet to log monthly utility consumption.
2. Identify one low-cost, achievable efficiency improvement and implement it.
3. Review the tracking data quarterly.

The most common mistake: Paying utility bills without anyone actually looking at whether consumption is trending up, down, or flat over time.

1. Is energy consumption genuinely tracked, not simply paid for with no real monitoring? — *Real, ongoing tracking, not bills paid without genuine attention to trends.*

Evidence: Consumption tracking record

2. Has the clinic genuinely identified and pursued at least one real, achievable efficiency improvement? — *A real, concrete improvement, not a generic aspiration with no actual implementation.*

Evidence: Specific improvement record

3. Is progress genuinely reviewed periodically? — *Real, periodic review, not an assumption that efficiency improves passively.*

Evidence: Review schedule

COMMON REASONS FOR A PARTIAL ANSWER

- Tracking exists but has never actually led to a real improvement.
- An improvement was made once but has never been followed up or reviewed since.

IMPLEMENTATION PLAN

When	What
Week 1	Set up basic consumption tracking.
Week 2-3	Identify and implement one achievable efficiency improvement.
Quarterly	Review tracking data for trends.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Tracking record review	Reviews the consumption tracking record for genuine, ongoing monitoring.

SUPERVISOR TIPS

- Ask to see the actual tracking data, not just a statement that energy use is “monitored.”

EVIDENCE BASE

International Finance Corporation. Greenhouse Gas Emissions Reduction in Healthcare Facilities. Washington DC: IFC; 2021.

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

27.5

Patients and Staff Are Genuinely Engaged in Sustainability Practice

STANDARD

Staff genuinely understand and participate in the clinic’s sustainability practices, and patients are genuinely made aware of relevant initiatives where appropriate — not a sustainability policy known only to management with no real staff or patient engagement.

In plain terms: Staff actually know what the clinic is doing to be more sustainable and genuinely take part in it — this isn’t just a management-level idea nobody else knows about.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Sustainability practices only actually function when the people carrying out daily operations understand and genuinely participate in them — waste segregation, resource conservation, and procurement choices all depend on frontline staff actually knowing what’s expected and why. A sustainability policy that exists only in a management document, never genuinely communicated or explained to staff, has no real chance of translating into actual practice, regardless of how well-intentioned the policy itself is.

WHAT GOOD LOOKS LIKE

- Staff can genuinely describe at least one real sustainability practice the clinic follows.
- Patients are genuinely made aware of relevant

COMMON FAILURE MODES

- Staff cannot name any specific sustainability practice when asked directly.
- Sustainability initiatives are kept entirely internal,

- Staff input on sustainability practice is genuinely sought and considered.

- Sustainability decisions are made unilaterally with no real staff voice.

WORKED EXAMPLE

IN PRACTICE

A clinic where sustainability efforts existed but staff were largely unaware.

BEFORE	The clinic manager had quietly switched to a more sustainable supplier for some items, but front-desk and clinical staff were unaware this had happened or why, and had never been asked for their own sustainability ideas.
ACTION	A brief team meeting introduced the supplier change and its rationale, a simple suggestion box was introduced for staff sustainability ideas, and a small sign in the waiting room noted the clinic's switch to recyclable packaging where used.
AFTER	The Monitor asked two staff members directly and both could describe the supplier change and its reasoning. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Hold a brief team discussion explaining any current sustainability practices.
2. Create a simple channel for staff to suggest their own sustainability ideas.
3. Communicate relevant initiatives to patients where genuinely appropriate.

The most common mistake: Sustainability decisions made and known only at the management level, never actually communicated to the staff carrying out daily operations.

1. Can staff asked directly describe at least one genuine sustainability practice the clinic follows? — *Real, demonstrated staff awareness, not a policy known only to leadership.*

Evidence: Staff interview

2. Are patients genuinely made aware of relevant sustainability initiatives where appropriate? — *Real, visible communication, not initiatives kept entirely internal.*

Evidence: Patient-facing communication

3. Is staff input on sustainability practice genuinely sought and considered? — *Real, two-way engagement, not a top-down policy with no genuine staff voice.*

Evidence: Staff suggestion record

COMMON REASONS FOR A PARTIAL ANSWER

- **Some staff are aware but awareness isn't consistent across the whole team.**
- **A suggestion channel exists but has never actually been used or promoted.**

IMPLEMENTATION PLAN

When	What
Week 1	Brief all staff on current sustainability practices and rationale.
Week 2	Introduce a simple staff suggestion channel.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a frontline staff member to describe a specific sustainability practice.

SUPERVISOR TIPS

- **Ask a non-management staff member, not the clinic director. —**
Frontline awareness is the real test of genuine engagement.

EVIDENCE BASE

Health Care Without Harm. Global Green and Healthy Hospitals Agenda. Reston: HCWH; 2020.

[ASF training courses on GMJ Academy →](#)

27.6

The Clinic Genuinely Plans for Climate-Related Operational Risk

CORE

The clinic genuinely considers climate-related risks to its own continuity of operation — extreme heat, power outages, supply chain disruption — and has a real, workable response, not an assumption that such risks only concern larger facilities.

In plain terms: The clinic has actually thought through what happens to patient care if there’s a heatwave, a power cut, or supplies don’t arrive — with a real plan, not an assumption that this only matters for big hospitals.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Climate-related disruptions — extreme heat events, grid instability, supply chain interruptions — affect facilities of every size, and an ambulatory clinic without backup planning may actually be more vulnerable than a larger hospital with redundant systems already in place. This is marked Core because continuity of outpatient care genuinely matters to the patients who depend on it, and a clinic that has never considered what happens during a real climate-related disruption risks an unplanned, chaotic response exactly when patients most need continuity.

WHAT GOOD LOOKS LIKE

- The clinic has genuinely identified its specific climate-related operational risks.
- A real, workable response plan exists for the most significant identified risk.

COMMON FAILURE MODES

- No climate-related risk has ever been formally identified or considered.
- A risk is acknowledged but no actual response plan has been prepared.
- A plan exists but has never been reviewed

WORKED EXAMPLE

IN PRACTICE

A clinic in a region with increasingly frequent summer power outages.

BEFORE

Power outages during summer heatwaves had twice forced same-day appointment cancellations in the past two years, but no formal plan existed for how to respond when this happened again.

ACTION

A simple response plan was developed: a defined patient communication protocol for outage-related cancellations, a small backup power solution for critical refrigerated medications, and an agreement with a nearby clinic for emergency patient redirection.

AFTER

The Monitor reviewed the documented plan and confirmed it had genuinely been tested in a tabletop exercise with staff. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Identify the clinic's most likely climate-related disruption based on its actual location and history.
2. Build a simple, workable response plan for that specific risk.
3. Walk through the plan with staff at least once.

The most common mistake: Assuming climate-related operational risk is a hospital-scale concern, overlooking the real, specific risks a smaller clinic faces too.

SELF-ASSESSMENT QUESTIONS

1. Has the clinic genuinely identified its specific climate-related operational risks? — *A real, specific risk identification, not a generic assumption of low exposure.*

Evidence: Risk identification document

Evidence: Response plan document

3. Is this plan genuinely reviewed and tested? — Real, periodic review and testing, not a plan assumed to remain adequate indefinitely.

Evidence: Testing/review record

COMMON REASONS FOR A PARTIAL ANSWER

- A risk is identified but the response plan is vague or genuinely untested.
- A plan exists for one risk but other genuinely significant local risks are unaddressed.

IMPLEMENTATION PLAN

When	What
Week 1	Identify the clinic's most significant, specific climate-related risk.
Week 2-3	Build a workable response plan.
Week 4	Walk through the plan with staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Plan review	Reviews the response plan and any record of testing or staff walkthrough.

SUPERVISOR TIPS

- **Ask about the clinic's actual local climate risk history, not a generic risk category.** — Specificity to the clinic's own real location and history is the key test.

EVIDENCE BASE

World Health Organization. Operational Framework for Building Climate Resilient Health Systems. Geneva: WHO; 2015.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

27.7

Sustainability Commitments Are Genuinely Reviewed, Not Static

STANDARD

The clinic’s sustainability goals and practices are genuinely reviewed and updated as circumstances change — not a document written once and never genuinely examined for whether it still reflects the clinic’s actual practice.

In plain terms: The clinic’s sustainability goals actually get revisited and updated over time — not written once and left to gather dust, disconnected from whatever the clinic is actually doing now.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Sustainability goals written at a single point in time inevitably drift from actual practice as circumstances change — new staff, new suppliers, new equipment, new local regulations. A document frozen at the moment it was written stops being a genuine reflection of the clinic’s real commitments and becomes, instead, a historical artifact disconnected from current reality. Genuine, periodic review is what keeps sustainability commitments actually meaningful rather than symbolic.

WHAT GOOD LOOKS LIKE

- Sustainability goals are genuinely reviewed on a real, defined schedule.
- A real, documented instance shows a goal genuinely being revised based on experience.
- Responsibility for review is genuinely assigned to a specific person or role.

COMMON FAILURE MODES

- A sustainability document was written once and has never been revisited.
- Goals have remained identical for years despite changed circumstances.
- No one is actually responsible for the review, so it happens informally if at all.

IN PRACTICE

A clinic whose sustainability goals had never been revisited since first written.

BEFORE

A one-page sustainability statement had been drafted three years earlier and filed away, with no one assigned to revisit it, and several of its specific commitments were no longer accurate given changes in suppliers and staff since.

ACTION

The office manager was formally assigned annual review responsibility, and the first review genuinely updated two outdated commitments to reflect the clinic's actual current practice.

AFTER

The Monitor reviewed the updated document, dated and showing specific, genuine revisions from the original. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Assign a specific named person responsibility for an annual sustainability review.
2. Compare the current document against actual current practice and update discrepancies.
3. Date each review so the record shows genuine, ongoing attention.

The most common mistake: A sustainability document that nobody is specifically responsible for revisiting, so it simply never gets reviewed.

SELF-ASSESSMENT QUESTIONS

1. Are sustainability goals genuinely reviewed on a real, defined schedule? — *A real, periodic review, not a goal document frozen at the point it was first written.*

Evidence: Review schedule and dated records

2. Is there a real, documented instance of a sustainability goal genuinely being revised based on actual experience? — *A concrete,*

3. Is responsibility for this review genuinely assigned to a specific person or role? — *A real, named accountability, not a review that depends on someone remembering to do it.*

Evidence: Assigned responsibility documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **A review schedule exists but hasn't actually been followed consistently.**
- **Review happens but produces no genuine changes, raising the question of its real rigor.**

IMPLEMENTATION PLAN

When	What
Week 1	Assign named responsibility for annual sustainability review.
Week 2	Conduct the first genuine review against current actual practice.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Revision history review	Reviews the document's revision history for genuine, dated updates.

SUPERVISOR TIPS

- **Ask who is specifically responsible for the review, not just whether a review process exists.** — Named accountability is what makes a review genuinely likely to happen.

EVIDENCE BASE

United Nations Environment Programme. Sustainable Healthcare Facilities Guidance. Nairobi: UNEP; 2022.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

all standards

Self-assess against these
criteria →

Standard 28 — Digital Care
& AI →

ASF STANDARDS · AMBULATORY · STANDARD 28

Standard 28 — Digital Care and Artificial Intelligence Systems for Care

7 criteria · 2 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 7, 6th Edition

CRITERIA IN THIS STANDARD

28.1 — Digital Systems Are Genuinely Evaluated Before Adoption

28.2 — Digital Care Never Disadvantages a Patient Who Cannot Use It

28.3 — Genuine Technical Support Is Available for Digital Systems

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

28.5 — AI Systems Are Genuinely Monitored for Unintended Consequences

28.6 — Staff Are Genuinely Consulted Before an AI System Is Introduced

28.7 — Accountability for AI-Assisted Care Is Explicitly Defined

28.8 — Patients Are Genuinely Informed When Their Care Involves AI

28.1 Digital Systems Are Genuinely Evaluated Before Adoption

STANDARD

Before adopting any new digital system — booking platform, patient portal, diagnostic-support tool — the clinic genuinely evaluates its cost, benefit, and compatibility with existing systems, not adopted on vendor assurance with no real internal evaluation.

In plain terms: Before the clinic signs up for a new digital tool, someone has actually checked it's worth it and will genuinely work with what the clinic already has — not adopted because a sales rep made it sound good.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Ambulatory clinics are frequent targets for digital health vendors offering booking, portal, and clinical-support tools, often with compelling pitches and limited internal IT capacity to independently evaluate them. A clinic that adopts tools based on enthusiasm rather than genuine evaluation risks ending up with systems that don't actually integrate with its patient records, create workflow friction rather than relief, or introduce risks nobody considered before go-live.

WHAT GOOD LOOKS LIKE

- A genuine cost/benefit evaluation happens before adoption.
- Compatibility with existing systems is genuinely checked.
- Potential unintended consequences are genuinely considered before go-live.

COMMON FAILURE MODES

- A system is adopted purely on a vendor demonstration with no independent check.
- Compatibility problems surface only after the system is already live.
- Unintended consequences are discovered only in hindsight.

IN PRACTICE

A clinic considering a new online booking platform.

BEFORE

A booking platform vendor offered a free trial month, and the clinic manager signed up directly with no check of whether it would actually sync with the existing patient record system.

ACTION

A simple evaluation was retroactively conducted during the trial, confirming genuine sync compatibility and identifying one real risk — missed appointment notifications for patients without email — which was addressed with an SMS fallback before full adoption.

AFTER

The Monitor reviewed the evaluation notes and the documented SMS-fallback decision. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a simple one-page evaluation checklist for cost, benefit, and compatibility.
2. Require it before any new digital system is adopted, even during a trial.
3. Specifically ask what could go wrong before going live.

The most common mistake: Starting a vendor's free trial without any real evaluation, then treating the trial's continuation as the de facto adoption decision.

SELF-ASSESSMENT QUESTIONS

1. Is a genuine cost/benefit evaluation conducted before adopting a new digital system? — *A real, documented evaluation, not a decision made purely on a sales presentation.*

Evidence: Evaluation checklist

2. Is compatibility with existing clinic systems genuinely checked before adoption? — *Real, verified compatibility, not an assumption.*

Evidence: Compatibility check record

before go-live? — *Real, proactive consideration, not effects discovered only in hindsight.*

Evidence: Pre-launch risk review

COMMON REASONS FOR A PARTIAL ANSWER

- **A free trial is treated as low-stakes and skips the evaluation entirely.** — A trial that leads to continued use should still be evaluated before genuine adoption.

IMPLEMENTATION PLAN

When	What
Week 1	Build a simple evaluation checklist.
Ongoing	Apply it before any new digital system, including trials.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Evaluation review	Reviews the evaluation record for a recently adopted digital system.

SUPERVISOR TIPS

- Ask about the most recently adopted digital tool, trial or otherwise.

EVIDENCE BASE

World Health Organization. Global Strategy on Digital Health 2020-2025. Geneva: WHO; 2021.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

28.2 Digital Care Never Disadvantages a Patient Who Cannot Use It

CORE

A genuine process ensures that patients who cannot use digital devices, lack internet access, or are otherwise unable to engage digitally are never disadvantaged in booking, communication, or care delivery — not digital

access for the patients least able to adapt.

In plain terms: A patient who can't use the online booking system or doesn't have internet still gets exactly the same real access to the clinic — a working alternative, not a quietly worse option.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Ambulatory clinics increasingly rely on digital booking and patient portals for efficiency, but the patients most likely to need outpatient care — older adults, those in lower-income circumstances, people with disabilities affecting digital use — are frequently the same patients least able to navigate a digital-only pathway. This is marked Core because the risk here is a real, direct equity failure: a clinic's digital modernisation can quietly reduce access for exactly the patients who need it protected.

WHAT GOOD LOOKS LIKE

- A genuine, equally functional alternative exists for patients who cannot use digital channels.
- New digital services are genuinely pre-tested with affected patient representatives.
- Real evidence shows the alternative delivers equivalent, undiminished service.

COMMON FAILURE MODES

- Phone booking exists nominally but is deprioritised in practice, with long waits.
- A new digital service launches with no testing among patients who might struggle.
- The alternative is never actually tested to confirm it's genuinely equivalent.

WORKED EXAMPLE

IN PRACTICE

A clinic that moved primarily to online appointment booking.

	Online booking was promoted as the primary channel, and the phone line, while technically still available, was staffed by whoever happened to be free, resulting in long, inconsistent wait times for patients who called instead.
ACTION	A specific staff member was assigned phone-booking coverage during peak hours, with wait times tracked to confirm genuine parity with the online booking experience.
AFTER	The Monitor called the booking line directly during business hours and reached a person within three minutes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Test your own non-digital booking channel directly, as a patient would.
2. Assign clear staffing responsibility for the alternative channel.
3. Track wait times to confirm genuine, ongoing parity.

The most common mistake: Leaving a non-digital channel technically available but under-resourced, so it quietly becomes a second-class option in practice.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, equally functional alternative for patients who cannot use a digital channel? — *A real, equivalent alternative, not a digital-only pathway with no real fallback.*

Evidence: Documented alternative channel

2. Was a new digital service genuinely pre-tested with representatives of patients who might struggle with it? — *Real, prior testing, not an assumption accessibility will work out.*

Evidence: Pre-launch testing record

3. Is there real evidence a patient using the alternative route received equivalent service? — *A real, demonstrated instance, not an untested theoretical alternative.*

Evidence: Direct test or comparison data

- **The alternative exists but is genuinely slower or less reliable than the digital route.**

IMPLEMENTATION PLAN

When	What
Week 1	Test the non-digital channel directly and measure wait time.
Week 2	Assign clear staffing coverage for the alternative.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Direct test	Personally tests the non-digital alternative channel.

SUPERVISOR TIPS

- **Call the clinic’s own phone line during business hours to test it directly.**

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health. Geneva: WHO; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

28.3

Genuine Technical Support Is Available for Digital Systems

STANDARD

The clinic has genuine access to technical support — in-house, vendor-provided, or contracted — for its digital systems, with testing before full implementation, not systems left running with no real technical support behind them.

In plain terms: When a digital system breaks, there’s a real person to call for help — not a system left to run itself with nobody actually responsible for fixing it.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Most ambulatory clinics lack dedicated in-house IT staff, which makes a genuine, accessible vendor support arrangement especially important — without it, a digital system failure can bring booking, records, or communication to a halt with no real path to resolution. A clinic doesn’t need its own IT department to meet this intent; it needs a real, known, accessible support relationship for every digital system it genuinely depends on.

WHAT GOOD LOOKS LIKE

- Genuine, accessible technical support exists for every digital system in use.
- Testing genuinely occurs before full implementation.
- A real, known escalation path exists for issues.

COMMON FAILURE MODES

- No clear support arrangement exists for a system in daily clinical use.
- Staff don’t know who to contact when something breaks.

WORKED EXAMPLE

IN PRACTICE	
<i>A clinic running a patient portal with no clear support contact.</i>	
BEFORE	The portal had been set up during initial onboarding, but staff had never been told who to contact for technical issues, and a recent outage had been resolved only after several days of searching for the original vendor contact.
ACTION	A support contact card with the vendor’s number was posted at the front desk, and the vendor’s actual response-time commitment was confirmed and documented.
AFTER	The Monitor asked a front-desk staff member who to call for a portal issue, and received a confident, correct answer. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every digital system in use and confirm a real support contact for each.
2. Post support contacts visibly for staff who use each system.

The most common mistake: Support contact information living only with whoever originally set up the system, with no documented, accessible record for others.

SELF-ASSESSMENT QUESTIONS

1. Does the clinic have genuine, accessible technical support for its digital systems? — *Real, available support, not a system left unsupported.*

Evidence: Support contract or arrangement

2. Were genuine testing and quality checks performed before full implementation? — *A real pre-launch check, not a system deployed untested.*

Evidence: Pre-launch testing record

3. Is there a real, known route to support when an issue arises? — *A genuine, known path, not staff left to troubleshoot alone.*

Evidence: Staff interview, posted contact

COMMON REASONS FOR A PARTIAL ANSWER

- Support knowledge depends on one staff member rather than a documented, shared record.

IMPLEMENTATION PLAN

When	What
Week 1	Document support contacts for every digital system in use.
Week 2	Post contacts visibly for staff who use each system.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a staff member who they'd contact for a digital system issue.

- **Ask a front-desk staff member, not just the clinic manager.**

EVIDENCE BASE

NHS Digital. Technology Assessment Criteria for Digital Health Products.
London: NHS Digital; 2022.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

STANDARD

Any artificial intelligence tool used to support diagnosis or triage in the clinic is introduced in accordance with applicable law, or where none exists, with available best-practice guidance such as WHO's AI ethics and governance guidance — not adopted with no reference to any external standard of responsible use.

In plain terms: Before using an AI tool in patient care, the clinic has actually checked what the law requires, or grounded its approach in real published guidance if there's no specific law — not made it up as it went along.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Smaller clinics adopting AI-assisted tools — increasingly common in areas like diagnostic imaging triage or symptom-checking — are just as subject to the responsibilities of genuine governance as larger facilities, even without dedicated compliance staff. A real, citable basis for how the clinic governs its AI tools, even a simple one, is what separates responsible adoption from an unexamined decision with no actual grounding.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- AI systems are genuinely introduced in line with applicable law, where it exists.
- Where no law exists, introduction is genuinely informed by recognized guidance.
- The clinic can identify, when asked, the specific basis for AI governance.

- No reference to law or guidance was made before adopting an AI tool.
- Nobody can say, when asked, what the governance basis actually is.

WORKED EXAMPLE

IN PRACTICE	
A clinic using an AI-assisted skin lesion triage tool.	
BEFORE	The tool had been adopted on a dermatologist's personal recommendation, with no check of applicable regulation or any formal reference to external guidance.
ACTION	A brief governance review confirmed no specific national AI medical device regulation yet applied, and formally adopted WHO's AI ethics guidance as the clinic's reference, documented in a one-page governance note.
AFTER	The Monitor reviewed the governance note and confirmed the dermatologist could name the guidance basis directly. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check for applicable AI-specific regulation in your jurisdiction.
2. Where none exists, formally adopt a recognized guidance source as reference.
3. Document this basis in a simple, one-page note.

The most common mistake: Adopting an AI tool on clinical recommendation alone with no separate governance check.

1. Is any AI system in clinical use genuinely introduced in line with applicable law? — *Real, verified compliance, not an assumption.*

Evidence: Regulatory check record

2. Where no law exists, is introduction genuinely informed by recognized guidance? — *A real, referenced source, not an ad hoc decision.*

Evidence: Documented guidance reference

3. Can the clinic identify, when asked, the specific basis for AI governance? — *A real, specific answer, not a vague assurance.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- A guidance source is named but hasn't actually been reviewed for its application here.

IMPLEMENTATION PLAN

When	What
Week 1	Research applicable AI regulation.
Week 2	Document a governance basis for each AI tool in use.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Governance note review	Reviews the documented governance basis for AI use.

SUPERVISOR TIPS

- Ask for the name of the specific guidance document, not a general assurance.

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health: Guidance on Large Multi-Modal Models. Geneva: WHO; 2024.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

28.5 AI Systems Are Genuinely Monitored for Unintended Consequences

STANDARD

The clinic genuinely monitors any AI-assisted diagnostic or triage tool for over-diagnosis, missed diagnosis, and other unintended consequences — not deploying an AI tool and assuming it works as intended with no real, ongoing scrutiny.

In plain terms: The clinic actually keeps checking whether its AI tools are working as expected — not deploying a tool once and simply trusting it from then on.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A clinic using an AI triage or diagnostic-support tool is depending on it to behave consistently well — but AI systems can fail in ways that aren't visible in any single encounter, and only genuine, ongoing review of its actual output against independent clinical judgment will catch a systematic pattern of error.

WHAT GOOD LOOKS LIKE

- AI output is genuinely, periodically audited against independent review.
- Patient concerns related to AI-assisted care are genuinely tracked.
- A documented instance exists of monitoring catching a real issue.

COMMON FAILURE MODES

- AI output is trusted with no ongoing audit of its real accuracy.
- No monitoring process has ever actually caught an issue.

WORKED EXAMPLE

IN PRACTICE

A clinic using an AI tool to flag abnormal imaging results.

PHIG	BEFORE	The tool had operated for a year with no formal check of its accuracy against actual clinical outcomes.
	ACTION	A simple quarterly audit was introduced, comparing a sample of flagged and unflagged results against independent radiologist review.
	AFTER	The Monitor reviewed the quarterly audit record showing genuine, independent comparison. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

- 1. Identify every AI tool currently influencing clinical decisions.
- 2. Establish a simple, periodic audit comparing output against independent review.

The most common mistake: Treating AI output as reliably correct by default, with no audit ever established to test that assumption.

SELF-ASSESSMENT QUESTIONS

- 1. Is AI-assisted output genuinely audited for over-diagnosis or missed diagnosis? — *Real, ongoing audit, not an assumption of reliability.*
Evidence: Audit record
- 2. Are patient concerns related to AI-assisted care genuinely tracked? — *A real, specific mechanism, not concerns absorbed into general feedback.*
Evidence: Tracking log
- 3. Is there a documented instance of monitoring identifying a genuine issue, with a real response? — *A real, concrete example, not a process that has never caught anything.*
Evidence: Issue response record

COMMON REASONS FOR A PARTIAL ANSWER

- Auditing happens but isn't genuinely independent of the AI vendor itself.

When	What
Week 1-2	Establish a periodic, independent audit process.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Audit review	Reviews the periodic AI audit record for genuine, independent comparison.

SUPERVISOR TIPS

- Ask whether the audit has ever actually found anything worth flagging.

EVIDENCE BASE

US Food and Drug Administration. Artificial Intelligence and Machine Learning in Software as a Medical Device. Silver Spring: FDA; 2023.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

28.6

Staff Are Genuinely Consulted Before an AI System Is Introduced

STANDARD

Clinical staff who will actually use a new AI tool are genuinely consulted before its introduction, with real training needs identified and addressed — not a tool rolled out to clinicians with no engagement beyond a brief notification.

In plain terms: Before a new AI tool goes live, the staff who will actually use it have had a real say — not just been told it’s coming.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

In a small clinical team, staff experience is especially valuable because there’s no large IT department standing between the decision and the people actually using the tool day to day — their early, genuine input

often catches practical friction that a vendor's generic roll-out plan misses entirely.

WHAT GOOD LOOKS LIKE

- Staff are genuinely consulted before, not after, an AI system's introduction.
- Consultation genuinely identifies training needs, actually delivered.
- Staff asked directly can describe genuine consultation.

COMMON FAILURE MODES

- Staff learn about a new tool only once the decision is already final.

WORKED EXAMPLE

IN PRACTICE

A clinic introducing an AI-assisted documentation tool.

BEFORE	Physicians received an email announcing the tool's launch the following week, with no real input sought beforehand.
ACTION	The launch was delayed by two weeks to hold a genuine consultation session, identifying a specific workflow concern that was addressed before go-live.
AFTER	The Monitor interviewed a physician who could describe the consultation and the resulting change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Hold a consultation session before finalizing any AI system decision.

The most common mistake: Treating a notification email as equivalent to genuine consultation.

1. Are staff genuinely consulted before a new AI system's introduction? — *Real, prior consultation, not a rollout announcement.*
Evidence: Consultation record

2. Does consultation genuinely identify training needs, actually addressed? — *Real needs matched by real, delivered training.*
Evidence: Training delivery record

3. Can staff describe having been genuinely consulted? — *Tests whether consultation actually registered with staff.*
Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- Consultation happened with one lead clinician but not the wider team.

IMPLEMENTATION PLAN

When	What
Before any launch	Hold genuine consultation with actual users.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks frontline staff whether they felt genuinely consulted.

SUPERVISOR TIPS

- Ask for a specific example of something changed because of staff input.

EVIDENCE BASE

Topol EJ. High-Performance Medicine: The Convergence of Human and Artificial Intelligence. *Nature Medicine*. 2019;25(1):44-56.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

28.7

Accountability for AI-Assisted Care Is Explicitly Defined

CORE

The clinic has genuinely considered and documented accountability for care decisions made with AI support — who is responsible when an AI-assisted decision is wrong — not leaving this as an unexamined question until it actually matters.

In plain terms: Everyone knows, in advance, who is actually responsible if an AI-supported decision turns out to be wrong — not a question nobody has thought through.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core for the same reason it is at any facility scale: without explicit accountability, a safety incident involving AI-assisted care risks becoming a confused dispute over responsibility exactly when clarity matters most — for the patient, the clinician, and the clinic’s own ability to learn from what happened.

WHAT GOOD LOOKS LIKE

- Clinical accountability for AI-supported decisions is explicitly documented.
- Clinicians genuinely understand their own accountability.
- A defined process exists for reviewing accountability in an incident.

COMMON FAILURE MODES

- Accountability has never been explicitly addressed.

WORKED EXAMPLE

IN PRACTICE

BEFORE	Staff were unclear whether responsibility for a missed urgent referral sat with the triage nurse or was somehow shared with the AI tool itself.
ACTION	A clear policy was documented: the AI tool is decision support only, and the reviewing clinician retains full accountability, taught explicitly during onboarding.
AFTER	The Monitor interviewed a triage nurse who could clearly state her own accountability. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Explicitly document where clinical accountability sits for each AI-supported decision.

The most common mistake: Leaving accountability ambiguous, assuming it will become clear if ever actually tested by a real incident.

SELF-ASSESSMENT QUESTIONS

1. Is clinical accountability for an AI-supported decision explicitly documented? — *A real, clear answer, not an assumption.*
Evidence: Documented accountability policy
2. Do clinicians genuinely understand their own accountability? — *Real, demonstrated understanding.*
Evidence: Staff interview
3. Is there a defined process for reviewing accountability in a safety incident? — *A real, usable process, not a question left open.*
Evidence: Incident review protocol

COMMON REASONS FOR A PARTIAL ANSWER

- A policy exists but hasn't been communicated to frontline staff.

When	What
Week 1	Document explicit accountability for each AI tool in use.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a clinician to describe their accountability when using an AI-supported tool.

SUPERVISOR TIPS

- Ask a clinician directly: if the AI flagged something wrong, who is responsible?

EVIDENCE BASE

European Commission. Ethics Guidelines for Trustworthy Artificial Intelligence. Brussels: European Commission; 2019.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

28.8

Patients Are Genuinely Informed When Their Care Involves AI

STANDARD

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

In plain terms: If AI is actually involved in part of a patient’s care, they’re genuinely told — not left to assume a human made every decision alone.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

A patient’s genuine right to understand their own care includes knowing, in plain terms, when a decision affecting them was shaped by an AI system rather than a clinician’s judgement alone. This isn’t a formality — a patient who genuinely knows AI was involved can ask informed questions, seek a second opinion with that context, or simply understand their care more completely. Disclosure buried in a general consent form a patient never actually reads does not meet this bar.

WHAT GOOD LOOKS LIKE

- Patients are genuinely informed when AI is involved in their care.
- Disclosure is genuinely understandable, in plain language.
- A patient can genuinely confirm they were told.

COMMON FAILURE MODES

- AI disclosure is buried in a general consent form, technically present but never genuinely read or understood.

WORKED EXAMPLE

IN PRACTICE	
A clinic using an AI-assisted triage tool at intake.	
BEFORE	AI’s role was mentioned only in a lengthy general consent document, which patients signed without genuine awareness that an AI tool had actually been involved in their specific visit.
ACTION	A brief, plain-language note was added at check-in: “An AI-assisted tool helped prioritise your visit; your clinician reviews every recommendation.”
AFTER	The Monitor interviewed a patient who could genuinely confirm they understood AI had been involved. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a brief, plain-language disclosure point at the moment care decisions involving AI are actually discussed with the patient.

The most common mistake: Treating a line buried in a general consent form as genuine disclosure, when the patient never actually registers it.

SELF-ASSESSMENT QUESTIONS

1. Is a patient genuinely informed when AI is involved in their care?
— *Real, standard disclosure.*
Evidence: Disclosure protocol

2. Is this disclosure genuinely understandable, not buried in technical language? — *A real, plain-language explanation.*
Evidence: Disclosure wording sample

3. Can a patient asked directly confirm they were genuinely told? —
A real, concrete confirmation.
Evidence: Patient interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Disclosure exists in a consent form but patients genuinely cannot recall or explain it when asked directly.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Draft plain-language disclosure wording for each AI-assisted care point and train staff to deliver it.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Patient interview	Asks a patient whether they were genuinely told AI was involved in their care.

SUPERVISOR TIPS

- **Ask a patient directly rather than relying on the consent form’s existence alone.**

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health: Guidance on Large Multi-Modal Models. Geneva: WHO; 2024.

[ASF training courses on GMJ Academy →](#)

← **Ambulatory Standards —
all standards**

**Self-assess against these
criteria →**

← **Standard 27 —
Sustainable Care**

**Standard 29 — Supporting
the Care Workforce →**

© 2026 Accréditation Sans Frontières · PHIG · Sheni Network

ASF STANDARDS · AMBULATORY · STANDARD 29

Standard 29 — Supporting the Care Workforce

8 criteria · 3 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 8, 6th Edition

CRITERIA IN THIS STANDARD

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

29.2 — Ongoing Competency Is Genuinely, Regularly Evaluated

29.3 — Staff Have Genuine Access to Ongoing Education and Skill Development

29.4 — Workforce Health and Safety Is Genuinely Protected

29.5 — Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved

29.6 — Staff Are Genuinely Protected From Violence and Aggression

29.7 — Workforce Feedback Is Genuinely Gathered and Acted On

29.8 — Sick Leave and Attrition Data Genuinely Inform Organisational Learning

29.9 — Equality, Diversity and Inclusion Across the Workforce Are Genuinely Monitored

Every Member of the Workforce Is

29.1 Genuinely Credentialed for Their Actual Role

CORE

Every member of the clinic’s workforce — employed staff, independent practitioners, contracted providers, and volunteers alike — has genuine assurance of the qualifications and scope of practice their role requires — not credentialing confined to directly-employed clinical staff while contracted roles go unchecked.

In plain terms: Everyone who actually delivers care here — on payroll, independently privileged, or locum-contracted — has had their real qualifications genuinely checked.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Ambulatory clinics frequently use locum or part-time practitioners to cover schedule gaps, and the real risk here is treating these roles as somehow less in need of genuine verification than full-time employed staff — a locum practitioner delivers real patient care, so their credentials deserve exactly the same real scrutiny.

WHAT GOOD LOOKS LIKE

- Genuine credential assurance extends to locum and contracted practitioners, not employed staff alone.
- Scope of practice is genuinely verified against real qualifications.
- A real, defined process exists for a scope mismatch.

COMMON FAILURE MODES

- A locum practitioner’s credentials are assumed verified by their agency, never independently checked.

IN PRACTICE

A clinic using a locum physician to cover a staff absence.

BEFORE

A locum physician was booked through an agency with no independent check of their licence directly with the medical board.

ACTION

A direct licence verification step was added to the locum booking process, confirmed before the first shift.

AFTER

The Monitor reviewed the verification record for the most recent locum engagement. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a direct licence-verification step to any locum or contractor booking process.

The most common mistake: Trusting an agency's own vetting without ever independently verifying credentials.

SELF-ASSESSMENT QUESTIONS

1. Does genuine credential assurance extend to every workforce category? — *Real, consistent coverage, not a gap for locum or contracted roles.*

Evidence: Credential verification records

2. Is each person's actual scope of practice genuinely verified? — *A specific, documented match, not an informal assumption.*

Evidence: Scope verification record

3. Is there a real process if someone practises outside their verified scope? — *A genuine corrective process.*

Evidence: Correction procedure

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens for regular staff but is inconsistent for one-off locum coverage.**

When	What
Week 1	Add direct verification to the locum booking process.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Credential review	Reviews verification records across staff categories including locums.

SUPERVISOR TIPS

- Ask specifically about the most recently engaged locum or contractor.

EVIDENCE BASE

The Joint Commission. Credentialing and Privileging Standards for Ambulatory Care. Oakbrook Terrace: TJC; 2023.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

29.2

Ongoing Competency Is Genuinely,
Regularly Evaluated

CORE

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

In plain terms: Staff competency keeps getting genuinely checked, not just verified once at hiring and never looked at again.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

In a small team, performance review can easily become informal to the point of non-existence — everyone knows everyone, and a genuine structured evaluation can feel unnecessary. But informal familiarity is not the same as a real, documented check that current competency genuinely matches current duties.

WHAT GOOD LOOKS LIKE

- Ongoing competency is genuinely evaluated on a real schedule.
- Evaluation genuinely covers actual current duties.
- A genuine gap triggers a real response.

COMMON FAILURE MODES

- No formal evaluation has occurred since initial hiring, relying instead on informal familiarity.

WORKED EXAMPLE

IN PRACTICE	
A small clinic relying entirely on informal supervisor impressions.	
BEFORE	No formal review had occurred for most staff in years; the clinic director simply “knew” everyone was doing fine.
ACTION	A simple annual review was introduced with role-specific competency checklists.
AFTER	The Monitor reviewed the first completed evaluation cycle. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a simple annual review with role-specific criteria, even in a small team.

The most common mistake: Relying on informal familiarity in a small team as a substitute for genuine, structured evaluation.

1. Is ongoing competency genuinely evaluated on a real, defined schedule? — *A real, periodic evaluation.*

Evidence: Evaluation records

2. Does evaluation genuinely cover actual current duties? — *A specific, role-relevant check.*

Evidence: Role-specific criteria

3. Does a genuine gap trigger a real response? — *A genuine corrective process.*

Evidence: Correction record

COMMON REASONS FOR A PARTIAL ANSWER

- **Review happens but relies entirely on informal impression, not structured criteria.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Build simple, role-specific evaluation criteria.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Evaluation review	Reviews a recent evaluation for genuine, structured substance.

SUPERVISOR TIPS

- **Ask to see an evaluation that identified a real gap, not just a clean pass.**

EVIDENCE BASE

Institute of Medicine. Health Professions Education: A Bridge to Quality. Washington DC: National Academies Press; 2003.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

29.3

Staff Have Genuine Access to Ongoing Education and Skill Development

STANDARD

Every workforce member has genuine access to ongoing education appropriate to a smaller clinic setting — internal updates, external courses, professional conferences — not education treated as a one-time induction event.

In plain terms: Staff can actually keep learning after they’re hired — not a single orientation treated as the end of their development.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A small clinic has genuinely less budget flexibility than a large hospital, but this makes genuine prioritization more important, not an excuse to drop education access entirely — even a modest, real commitment keeps staff skills current.

WHAT GOOD LOOKS LIKE

- Genuine, ongoing access to education beyond induction.
- Real development opportunities, not only compliance training.
- Staff can describe a real opportunity taken.

COMMON FAILURE MODES

- No education budget exists at all beyond mandatory compliance modules.

WORKED EXAMPLE

IN PRACTICE

A clinic with no education budget beyond compliance training.

BEFORE

Staff had not attended any external training in over two years; the only recurring training was mandatory compliance modules.

ACTION A modest annual per staff education allowance was introduced, along with quarterly internal lunch-and-learn sessions.

AFTER The Monitor interviewed staff who could each describe a recent education opportunity taken. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Allocate even a modest annual education allowance per staff member.

The most common mistake: Treating compliance training as a substitute for genuine professional development.

SELF-ASSESSMENT QUESTIONS

1. Does every workforce member have genuine, ongoing access to education? — *Real, continuing access.*

Evidence: Education policy and budget

2. Are genuine development opportunities offered beyond compliance minimums? — *Real opportunities.*

Evidence: Training calendar

3. Can staff describe a real opportunity taken in the past year? — *A real, specific example.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- A budget exists but coverage to actually attend rarely materializes.

IMPLEMENTATION PLAN

When	What
Week 1-2	Allocate a real, modest education budget.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks staff to describe a specific recent education opportunity.

- **Ask a junior staff member, not only senior staff.**

EVIDENCE BASE

World Health Organization. Global Strategy on Human Resources for Health: Workforce 2030. Geneva: WHO; 2016.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

29.4 Workforce Health and Safety Is Genuinely Protected CORE

The clinic genuinely protects the health and safety of its workforce — required vaccinations, personal protective equipment, prevention of needlestick and manual handling injuries — not staff safety treated as secondary to patient safety.

In plain terms: The people working here are genuinely kept safe — real protective equipment actually used, real steps taken to prevent injury.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Needlestick and similar occupational injuries occur in ambulatory settings too, wherever injections, blood draws, or minor procedures happen — the risk doesn't disappear because the setting is smaller or lower-acuity than a hospital.

WHAT GOOD LOOKS LIKE

- PPE is genuinely available and used.
- Specific measures prevent needlestick and manual handling injuries.

COMMON FAILURE MODES

- Older, non-safety-engineered needle devices remain in use.

WORKED EXAMPLE

IN PRACTICE

A clinic still using older needle devices.

BEFORE

Older, non-safety-engineered needles were still in use for routine blood draws, and a needlestick incident the prior year had gone informally handled with no real review.

ACTION

Safety-engineered devices were adopted clinic-wide, and a simple incident-reporting form was introduced.

AFTER

The Monitor confirmed safety-engineered devices in use and reviewed the new reporting log. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check current needle devices are safety-engineered.

The most common mistake: Assuming lower patient volume means lower occupational injury risk.

SELF-ASSESSMENT QUESTIONS

1. Is PPE genuinely available and used? — *Real, observed use.*

Evidence: Direct observation

2. Are specific measures in place to prevent needlestick injuries? —

Real, specific measures.

Evidence: Equipment and training records

3. Are vaccinations genuinely tracked? — *Real, verified tracking.*

Evidence: Vaccination records

COMMON REASONS FOR A PARTIAL ANSWER

- **Equipment is current but reporting of incidents remains informal.**

When	What
Week 1	Audit needle devices and PPE.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Direct observation	Observes equipment and PPE use directly.

SUPERVISOR TIPS

- Check the actual needle devices in use, not just the stated policy.

EVIDENCE BASE

World Health Organization. Health Worker Safety Charter. Geneva: WHO; 2020.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

29.5 Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved STANDARD

A genuine process exists for investigating and resolving workplace issues raised by staff — including whistleblowing concerns — with real protection from adverse treatment, not a grievance process that exists on paper with no real follow-through.

In plain terms: When staff raise a concern, it actually gets looked into, and the person who raised it is genuinely protected.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

In a small clinic, every channel for raising a concern can run directly through the clinic owner or director, which is exactly the structure that makes genuine, independent protection most important — staff need a real path that doesn't depend entirely on the person a concern might be about.

WHAT GOOD LOOKS LIKE

- A genuine, accessible process exists.
- Real evidence of genuine resolution.
- Genuine protection from adverse treatment.

COMMON FAILURE MODES

- Every concern routes directly through the owner, with no independent alternative.

WORKED EXAMPLE

IN PRACTICE	
<i>A clinic where all concerns went directly to the owner-director.</i>	
BEFORE	Staff had no route to raise a concern independent of the owner, which discouraged raising concerns about the owner's own practices.
ACTION	An external, independent reporting channel was arranged through ASF's regional contact point.
AFTER	The Monitor confirmed staff were aware of and trusted the independent channel. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Establish a channel independent of direct ownership for raising concerns.

The most common mistake: Every reporting channel routing through the single person most likely to be the subject of a concern.

1. Is there a genuine, accessible process for raising issues? — *A real, known process.*

Evidence: Process documentation

2. Is there real evidence of genuine resolution? — *Genuine follow-through.*

Evidence: Resolution log

3. Are staff genuinely protected from adverse treatment? — *Real, demonstrated protection.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A process exists but routes entirely through the owner or director.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Establish an independent reporting channel.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks staff whether they'd feel safe raising a concern.

SUPERVISOR TIPS

- **Ask staff privately whether they know a route independent of the owner.**

EVIDENCE BASE

International Labour Organization. Violence and Harassment Convention, 2019 (No. 190). Geneva: ILO; 2019.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

29.6

Staff Are Genuinely Protected From Violence and Aggression

STANDARD

The clinic takes genuine, concrete steps to protect staff from aggression — from patients or visitors, ranging from verbal abuse through to physical threat — not workplace aggression treated as an unavoidable feature of healthcare work, including in a lower-acuity outpatient setting.

In plain terms: Real, specific steps are taken to keep staff safe from aggression — not an assumption that this is just part of the job.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Ambulatory settings are sometimes assumed lower-risk for aggression than emergency departments, but distressed or frustrated patients and family members can still create real, concerning situations at the front desk or in exam rooms — and a clinic with no plan at all is caught unprepared.

WHAT GOOD LOOKS LIKE

- Genuine, specific protective measures exist.
- Incidents are genuinely tracked.
- Staff can describe a real instance where a measure worked.

COMMON FAILURE MODES

- No protocol exists at all for an aggressive or threatening patient encounter.

WORKED EXAMPLE

IN PRACTICE

A front desk with no de-escalation protocol.

BEFORE

Front-desk staff had no training or protocol for an aggressive patient interaction, and a recent

incident had left a receptionist shaken with no formal follow-up.

ACTION	Basic de-escalation training was delivered, and a simple incident log was introduced.
AFTER	The Monitor reviewed the incident log and confirmed training had been delivered. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

- 1. Deliver basic de-escalation training to front-facing staff.

The most common mistake: Assuming a lower-acuity outpatient setting doesn't need real protective measures.

SELF-ASSESSMENT QUESTIONS

- 1. Are genuine, specific measures in place? — *Real, specific measures.*
Evidence: Training/protocol documentation
- 2. Are incidents genuinely tracked? — *Real, systematic tracking.*
Evidence: Incident log
- 3. Can staff describe a real instance where a measure worked? — *A real, concrete example.*
Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- Training was delivered once but hasn't been refreshed since.

IMPLEMENTATION PLAN

When	What
Week 1-2	Deliver basic de-escalation training and introduce incident logging.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Incident log review	Reviews the incident log for genuine, ongoing tracking.

- **Ask front-desk staff directly about their real experience.**

EVIDENCE BASE

World Health Organization. Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva: WHO/ILO/ICN/PSI; 2002.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

29.7 Workforce Feedback Is Genuinely Gathered and Acted On

STANDARD

The clinic has a genuine, systematic approach to gathering staff feedback, with real analysis and a genuine, implemented response — not feedback collected occasionally with no real pattern of actual improvement.

In plain terms: Staff get genuinely asked how working here actually is, and real changes happen as a result.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

In a small team, feedback often happens informally in passing conversation, which can feel sufficient but lacks the real, structured follow-through that ensures feedback actually translates into change, rather than being heard and then forgotten.

WHAT GOOD LOOKS LIKE

- Feedback is genuinely gathered systematically.
- Feedback is genuinely analysed.
- A documented instance shows a genuine, implemented change.

COMMON FAILURE MODES

- Feedback happens only informally, with no structured record or follow-through.

IN PRACTICE

A clinic relying entirely on informal hallway conversations.

BEFORE

Staff feedback happened only informally; no structured survey or record of concerns existed.

ACTION

A brief annual survey was introduced, with results shared back at a team meeting and one specific scheduling change made in response.

AFTER

The Monitor reviewed the survey results and the resulting scheduling change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce even a brief annual feedback survey.

The most common mistake: Relying on informal conversation as a substitute for genuine, structured, recorded feedback.

SELF-ASSESSMENT QUESTIONS

1. Is feedback genuinely gathered on a systematic basis? — *Real, ongoing collection.*

Evidence: Survey records

2. Is feedback genuinely analysed? — *A real, documented analysis.*

Evidence: Analysis notes

3. Is there a documented instance of feedback genuinely leading to a change? — *A real, concrete example.*

Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- Feedback is gathered but results are never shared back with staff.

IMPLEMENTATION PLAN

When	What
Week 1-2	Design and launch a brief staff survey.

Method	What	Detail
DOCUMENT	Survey review	Reviews survey results and resulting changes.

SUPERVISOR TIPS

- Ask staff for a specific example of a change resulting from feedback.

EVIDENCE BASE

NHS England. NHS Staff Survey National Results. Leeds: NHS England; 2023.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

Sick Leave and Attrition Data

29.8 Genuinely Inform Organisational Learning

STANDARD

The clinic genuinely monitors staff sick leave and the real reasons people leave, using this to inform genuine changes supporting workforce wellbeing and retention — not attrition treated as an unexamined, unavoidable cost of doing business.

In plain terms: The clinic actually looks at why staff get sick or leave, and genuinely uses what it learns to make things better.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A small clinic losing even one or two staff members represents a genuinely significant proportion of its total workforce, making real attention to why people leave especially consequential — a pattern that might look statistically small at a hospital is often a real, urgent signal at a small clinic's scale.

WHAT GOOD LOOKS LIKE

- Sick leave data is genuinely monitored.
- Real reasons for leaving are actually captured.
- A documented instance shows this data genuinely informing a change.

COMMON FAILURE MODES

- Departures are treated as individually self-explanatory, with no real pattern ever examined.

WORKED EXAMPLE

IN PRACTICE

A clinic that had lost two nurses within six months with no real investigation.

BEFORE

Both departures were treated as unrelated personal decisions, with no exit interview conducted for either.

ACTION

A simple exit interview process was introduced, and a review of the two departures retrospectively revealed a shared concern about scheduling flexibility.

AFTER

The Monitor reviewed the exit interview notes and the resulting scheduling policy change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a simple, structured exit interview for every departure.

The most common mistake: Treating each individual departure as self-explanatory, missing a real shared pattern across several.

SELF-ASSESSMENT QUESTIONS

1. Is sick leave data genuinely monitored? — *Real, ongoing analysis.*
Evidence: Sick leave records

2. Are real reasons for leaving actually captured? — *Real, specific exit data.*

3. Is there a documented instance of this data genuinely informing a change? — *A real, concrete example.*

Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- **Exit interviews happen inconsistently, with some departures never covered.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a simple, structured exit interview process.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Exit data review	Reviews exit interview records and any resulting change.

SUPERVISOR TIPS

- **Ask whether any recent departure pattern has been genuinely examined.**

EVIDENCE BASE

International Council of Nurses. The Global Nursing Workforce and the COVID-19 Pandemic. Geneva: ICN; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

Equality, Diversity and Inclusion

29.9 Across the Workforce Are Genuinely Monitored

STANDARD

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

In plain terms: The clinic actually looks at real patterns — who gets hired, which shifts people get, who gets promoted — not just assuming things are fair because nobody has formally complained.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Inequity in recruitment, scheduling, or promotion can genuinely persist for years without a single formal complaint — people often don’t report a pattern they can’t fully see themselves, or don’t trust reporting to change anything. Genuine, proactive monitoring of real workforce data is what actually surfaces a pattern that individual complaints alone would likely never reveal.

WHAT GOOD LOOKS LIKE

- Workforce data is genuinely monitored for patterns.
- A genuine pattern triggers a real response.
- A real instance shows monitoring informing a change.

COMMON FAILURE MODES

- No formal complaint has been raised, so the organisation genuinely assumes no issue exists, with no actual data ever reviewed.

WORKED EXAMPLE

IN PRACTICE	
<i>A clinic that had never reviewed its own scheduling data for patterns.</i>	
BEFORE	Shift scheduling was managed informally with no genuine review of whether certain staff consistently received less favourable assignments.
ACTION	A quarterly scheduling equity review was introduced, which identified and corrected a genuine, unintentional pattern.

AFTER The Monitor reviewed the review documentation and the resulting correction. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a regular review of recruitment, scheduling, and promotion data for genuine patterns.

The most common mistake: Assuming fairness exists because no one has formally complained, with no actual data ever reviewed.

SELF-ASSESSMENT QUESTIONS

1. Is workforce data genuinely monitored for patterns of inequity? —
A real, documented monitoring process.
Evidence: Monitoring protocol
2. Where a genuine pattern is identified, is there a real, defined response? — *A genuine corrective process.*
Evidence: Response record
3. Is there a real, documented instance of this genuinely informing a change? — *A concrete, real example.*
Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- **Data exists but has genuinely never been reviewed specifically for equity patterns.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a quarterly equity review of recruitment, scheduling, and promotion data.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Equity review record	Reviews the monitoring data and any resulting corrective action.

- **Ask to see the actual data behind the last equity review, not just a statement that one happened.**

EVIDENCE BASE

World Health Organization. Gender Equity and Human Rights in the Health Workforce. Geneva: WHO; 2019.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Ambulatory Standards — all standards**

Self-assess against these criteria →

← **Standard 28 — Digital Care & AI**