

Ambulatory Clinic Standards

The complete ASF accreditation standard for ambulatory clinic facilities. Every criterion is published in full — statement, classification, and the verification questions used by Monitors and supervisors. Free. No account required.

25 standards · 121 criteria · 96 non-negotiable · 25 core · 0 standard · Version 3.1



Accréditation Sans Frontières

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How to read this page: Each standard groups related criteria. Each criterion has a classification — **Non-Negotiable** (all must be met; any single failure bars accreditation), **Core** ($\geq 85\%$ for accreditation, $\geq 70\%$ for certification), or **Standard** ($\geq 70\%$ for accreditation). The verification questions show what a Monitor checks. To test your facility against these criteria, use the free self-assessment tool.

STANDARD 1 · MANDATORY

Access & Arrival

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.

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.
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.
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.

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.

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.
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.
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.

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.

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.
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.
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.

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.

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.
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.
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.

STANDARD 2 · MANDATORY

Reception & Information

2.1 Patients Know Their Rights

Non-Negotiable

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

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.
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.
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.

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.

1. Is pricing disclosed before treatment begins, not only on the final invoice? — Disclosure after the fact doesn't allow an informed decision.
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.
3. Can a patient describe roughly what they were told a service would cost? — Tests whether the disclosure actually registered.

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.

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

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.

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.

- 1.** Is health information routinely delivered in plain language? — Genuinely accessible language, not clinical terms used without explanation.
- 2.** Is patient understanding actively verified, such as through teach-back? — An active check, not passive delivery followed by assuming it landed.
- 3.** Are materials available in the languages patients actually need? — Matched to actual population need.

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.

- 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.
- 2.** Is honest wait-time information visible or communicated to waiting patients? — Genuine, reasonably accurate information, not a vague reassurance.
- 3.** Is there a mechanism to notice if a waiting patient's condition changes? — Active monitoring, not only queue order.

STANDARD 3 · MANDATORY

Environment & Shared Spaces

3.1 Water Supply Is Safe and Monitored

Non-Negotiable

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

- 1.** Is water quality tested on a defined, regular schedule, with records kept? — An assumption is not a verified fact.
- 2.** Is there a documented contingency plan for water supply interruption? — A plan written during an actual interruption is not a contingency plan.
- 3.** Are test results reviewed and acted on, not just filed? — A concerning result nobody reads is no better than not testing.

3.2 Medical Equipment Is Maintained on Schedule

Non-Negotiable

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

- 1.** Is there a documented maintenance schedule covering all clinical equipment? — A defined, proactive schedule, not reactive maintenance.
- 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.
- 3.** Is there a named person responsible for the maintenance programme? — Diffuse responsibility usually means inconsistency.

3.3 Shared Spaces Are Genuinely Clean

Core

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

1. Is there a documented cleaning schedule with records kept? — A specific, dated schedule, not a general statement.
2. Is cleaning verified through more than a visual check? — Visual cleanliness and actual microbial cleanliness aren't the same thing.
3. Are high-touch surfaces specifically included? — Door handles and switches are easy to overlook relative to visible surfaces.

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.

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.
2. Is the register reviewed on a defined schedule by clinic leadership? — Review at a level that can act across domains.
3. Does the register prioritise risks, not just list them? — A genuine tool ranks what needs attention first.

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.

1. Is diagnostic equipment calibrated against a defined schedule, not just confirmed to be running? — Calibration verifies accuracy; maintenance only verifies function.
2. Is calibration performed or verified by a qualified, external or certified source? — Self-assessed calibration by untrained staff doesn't meet this.
3. Is equipment found out of calibration removed from use until corrected? — Continuing to use miscalibrated equipment defeats the purpose of checking at all.

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.

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

STANDARD 4 • MANDATORY

Care & Treatment

4.1 Consent Is Real, Not a Signature

Non-Negotiable

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.

1. Does a genuine conversation happen before the procedure, not just a form handed over? — An actual explanation, not a document presented for signature.
2. Can the patient explain back, in their own words, what will happen and why? — Tests genuine understanding, not just that a conversation occurred.
3. Are alternatives and the option to decline genuinely discussed? — Consent that only presents one path isn't genuinely informed.

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.

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.
2. Is credential currency rechecked periodically, not only at hiring? — A licence can lapse after hiring without anyone noticing.
3. Is there a defined process if a credential is found lapsed or invalid? — Discovery without a defined response provides no real protection.

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.

1. Is hand hygiene performed before and after every patient contact, not just when convenient? — Every contact, not a general habit applied inconsistently.
2. Are sanitiser or handwashing stations genuinely accessible at the point of care? — Accessible at the moment needed, not down the hall.
3. Is hand hygiene compliance directly observed periodically, not assumed? — Direct observation, not reliance on self-report.

4.4 Every Patient Gets a Real Assessment

Non-Negotiable

Every patient receives a genuine clinical assessment appropriate to their presenting concern, documented specifically, not a generic note applied regardless of the actual visit.

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.
2. Is the assessment documented at the time of the visit, not reconstructed later? — Contemporaneous documentation is more reliable than reconstruction.
3. Would another clinician reading this assessment understand what was actually found? — Tests genuine usefulness to a future reader, not just completion.

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.

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

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.

1. Are two identifiers checked before every medication, procedure, and specimen collection? — Applied consistently across every point of contact, not just one.
2. Is a room or appointment slot number ever used as an identifier? — These change and are never acceptable as an identifier alone.
3. Is identification checked independently at each new point of contact? — Not relying on identification done earlier in the same visit.

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.

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

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.

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

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.

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.
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.
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.

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.

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

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.
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.

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.

1. Is there a written non-discrimination policy covering care decisions specifically? — Covering clinical care, not just a general workplace policy.
2. Can staff describe specific ways they ensure equitable treatment? — Concrete practices, not a general assurance.
3. Is there a mechanism to report perceived discriminatory treatment specifically? — A pathway that names discrimination directly, not folded anonymously into general feedback.

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.

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

STANDARD 5 · MANDATORY

Safety & Emergency Preparedness

5.1 Recognising an Emergency Beyond This Clinic's Capacity

Non-Negotiable

Staff are trained to recognise when a patient's condition exceeds what this clinic can safely manage, with a defined, immediate escalation process to get the patient to appropriate care fast — not a generic sense that "someone will know what to do."

1. Do staff have specific, trained criteria for recognising a condition beyond this clinic's capacity? — Specific, trained criteria, not general clinical instinct alone.
2. Is there a defined, immediate escalation process once such a condition is recognised? — A specific, known process, not improvisation in the moment.
3. Do all clinical staff, not just senior ones, know this process confidently? — Genuine, distributed readiness, not knowledge held only by the most experienced person present.

5.2 Basic Resuscitation Equipment Is Ready

Non-Negotiable

Basic resuscitation equipment appropriate to an ambulatory setting is checked every operating day, fully stocked and functional, with staff current on life support certification.

1. Is resuscitation equipment checked every operating day, with a documented record? — Every operating day, verifiably, not "regularly."

2. Is all equipment found fully stocked and functional at each check? — A check that finds gaps but doesn't trigger immediate resupply provides only partial protection.
3. Are all relevant staff current on life support certification? — A lapsed certification discovered during an emergency is a preventable failure.

5.3 Fire Safety Is Real, Not Theoretical

Non-Negotiable

Fire safety equipment is tested on schedule and an evacuation drill has actually been run, with real participation, not merely documented as a policy requirement.

1. Is fire safety equipment tested on a defined schedule, with records kept? — Extinguishers and alarms specifically, not general assumption of functionality.
2. Has an evacuation drill actually been run, with real staff participation? — A physical drill, not a tabletop discussion of the plan.
3. Are evacuation routes kept genuinely clear, not obstructed in practice? — A route clear on paper but blocked in reality fails when it matters.

5.4 Internal Emergency Alerts Are Clear and Trained

Non-Negotiable

The clinic has a clearly defined internal emergency alert system, whether colour-coded or plain-language, with every staff member trained and able to respond correctly.

1. Does the clinic have a clearly documented internal emergency alert system? — A specific, written system, not an assumption staff will understand from prior experience elsewhere.
2. Are all staff, including part-time or covering staff, trained on this specific system? — Facility-specific training, not reliance on what a code meant at a previous workplace.
3. Can staff correctly state the required response for each alert type used? — Understanding the required response, not just recognising an alert occurred.

STANDARD 6 · MANDATORY

Aftercare & Follow-up

6.1 Every Patient Leaves With a Real, Understood Plan

Non-Negotiable

Every patient leaves with a documented aftercare plan they can explain back in their own words — not a printed sheet handed over on the way out the door.

1. Does every patient receive a documented aftercare plan specific to their visit? — Content specific to this patient's condition, not a generic sheet.
2. Can a patient contacted after the visit explain their own plan in their own words? — Tests whether the plan was actually understood, not just handed over.
3. Does the plan cover medication, warning signs, and who to contact if something goes wrong? — A plan missing any of these leaves a genuine gap in what the patient needs.

6.2 A Real Mechanism Confirms the Patient Reached Their Next Step

Non-Negotiable

For any patient referred elsewhere or given a follow-up requirement, a genuine, defined mechanism confirms they actually got there — not merely available on request if the patient happens to reach back out.

1. Is there a defined mechanism to actively confirm patients reached their referral or follow-up, not just availability on request? — The clinic initiating contact, not merely being reachable if the patient calls first.
2. Does the mechanism apply consistently, not only for cases staff happen to remember? — A system that depends on individual staff memory is not a reliable system.

3. Is there a defined escalation if follow-up reveals the patient never went? — Detecting a gap is only useful if something happens as a result.

6.3 Patients Can Complain After Leaving, and Complaints Are Read

Core

A complaint channel exists that a patient can use after leaving the clinic, with evidence that complaints are genuinely read and acted on, not merely collected.

1. Can a patient submit a complaint after leaving, not only while present? — A way to reach the clinic afterward, not only an in-person suggestion box.
2. Is there evidence complaints are actually read and result in a response? — A collected complaint with no follow-through provides no real value.
3. Have any complaints led to a documented change in practice? — A system that has never led to a change is worth questioning.

STANDARD 7 · MANDATORY

Governance & Management

7.1 Leadership Is Real and Accountable

Non-Negotiable

The clinic has clear, named clinical and operational leadership with defined authority over safety and quality — not an informal arrangement functioning without real oversight structure.

1. Is there a named person with defined authority over clinical safety and quality? — A specific name and defined authority, not an informal arrangement.
2. Does this person actively review quality and safety matters, not only administrative ones? — Genuine engagement with quality, not administration alone.
3. Is there a documented process for raising a safety concern to this leadership? — A specific, known pathway, not an assumption someone would eventually hear about it.

7.2 Policy Actually Gets Followed

Non-Negotiable

A policy framework exists and staff can describe how it's genuinely applied in practice, not merely confirm that policies are filed and technically available.

1. Can staff describe how a specific, named policy is actually applied in their daily work? — Not whether they know a policy exists — whether they can describe applying it.
2. Is there a mechanism to check policy adherence, not just policy existence? — A genuine audit or spot-check process, distinct from confirming documents are filed.
3. When a policy-practice gap is found, is there a defined response? — Identifying a gap without addressing it provides limited real value.

7.3 Patient Information Stays Private

Non-Negotiable

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

1. Are screens and monitors positioned so patient information isn't visible to others? — Physical positioning, checked directly.
2. Are clinical conversations conducted where they can't be overheard? — Doors or private spaces genuinely used, not just available.
3. Do staff apply confidentiality practices consistently, not only when reminded? — Habitual, not situational.

7.4 Medical Records Are Complete and Secure

Non-Negotiable

Records contain all mandatory elements, are regularly audited for completeness, and are protected by access controls and a genuine breach response plan.

1. Is there a defined list of mandatory record elements, audited regularly? — A specific, checkable list and genuine audit, not assumed completeness.
2. Are access controls in place restricting data access to staff who need it for their role? — Role-based restriction, not general access available to anyone.
3. Is there a documented, specific breach response plan? — A named process, not a general statement of concern.

7.5 Incidents Are Actually Reported

Non-Negotiable

An accessible incident reporting system exists and staff genuinely use it — measured by real reporting volume and pattern, not merely by the system's technical availability.

1. Is the incident reporting system genuinely accessible to all staff? — Accessible at the point of work, not buried in an administrative system.
2. Does actual reporting volume suggest genuine use? — A system receiving almost no reports over time suggests a use problem, not perfect safety.
3. Do staff believe they can report without fear of punitive consequence? — Genuine psychological safety, not just a stated non-punitive policy.

7.6 Staff Scope of Practice Is Verified

Core

Every clinical staff member's actual duties are matched to their verified scope of practice and licence category, not assumed appropriate because they've been performing the role for some time.

1. Is each staff member's actual duties matched against their verified licence category and scope? — A specific comparison, not an assumption that current duties are appropriate.
2. Is this comparison repeated periodically, not only done once at hiring? — Duties can expand gradually over time without a formal decision ever being made.
3. Is there a defined process if a mismatch is found? — Identifying a mismatch without correcting it provides no real protection.

7.7 Leadership Reviews Overall Performance at Planned Intervals

Non-Negotiable

Clinic leadership formally reviews overall quality and safety performance at a defined, regular interval — not only in reaction to an individual incident — covering trends, not single events.

1. Does leadership review overall quality and safety performance at a defined, regular interval? — A specific, planned interval, not only when something goes wrong.
2. Does the review cover trends and patterns, not only a list of individual incidents? — Trend analysis reveals patterns a single-incident view misses entirely.
3. Does the review lead to documented decisions or actions, not just discussion? — Review without resulting action provides limited real value.

7.8 Quality Objectives Are Set, Specific, and Tracked

Core

The clinic sets specific, measurable quality objectives for the coming period, and tracks progress against them — not a general aspiration to "provide good care" with no way to know if it's actually happening.

1. Are there specific, measurable quality objectives set for the coming period? — A specific, numeric or otherwise measurable target, not a general aspiration.
2. Is progress against these objectives actually tracked? — Tracked progress, not an assumption things are improving.

3. Are objectives communicated to relevant staff, not held only by leadership? — Staff who don't know the objective can't meaningfully contribute to it.

7.9 A Continual Improvement Process Exists, Not Only Reaction to Individual Incidents

Core

The clinic has a defined process for identifying and acting on improvement opportunities generally, separate from and in addition to responding to specific incidents as they occur.

1. Is there a defined process for identifying improvement opportunities, separate from incident response? — A proactive process, not only reaction to something having gone wrong.
2. Have any improvements been made through this process recently, not only through incident-driven correction? — A real, recent example distinguishes genuine practice from a policy on paper.
3. Are staff able to suggest improvement ideas through a known channel? — Front-line staff often see improvement opportunities leadership doesn't.

7.10 Patient Feedback Has an Independent Channel, Not Just an Internal One

Core

Patients and families have a genuine, independent channel to raise concerns, praise, and ideas — one that reaches a body outside the clinic's own management, not only an internal suggestion box or feedback form the clinic itself reviews and answers.

1. Do patients have a channel that reaches a body genuinely independent of the clinic's own management? — A real external channel, not an internal form the clinic reviews itself.
2. Are concerns raised through it genuinely acknowledged and answered, not left to sit? — Real, timely responses, not silence after submission.
3. Do patterns in what patients raise genuinely inform real changes at the clinic? — Evidence of at least one real change traceable to patient feedback.

STANDARD 8

Dental Practice

8.1 Dental Instrument Sterilization Is Monitored, Not Just Performed

Non-Negotiable

Sterilization of reusable dental instruments is verified through mechanical, chemical, and biological monitoring together, on a defined schedule, with results documented — not assumed complete because the sterilizer cycle finished.

1. Is every sterilization cycle monitored using mechanical, chemical, and biological indicators together, not just one? — All three layers together — a completed cycle alone doesn't confirm sterility was achieved.
2. Is a biological indicator run at least weekly, per manufacturer and international guidance? — Biological testing is the only method that directly confirms spore-killing capability.
3. When a monitoring result is inadequate, are affected instrument packs reprocessed before any use on a patient? — An inadequate result without reprocessing defeats the purpose of monitoring at all.

8.2 Aerosol-Generating Procedures Have Real Ventilation and PPE Control

Non-Negotiable

Procedures that generate dental aerosols use a defined combination of high-volume evacuation, appropriate respiratory protection, and adequate room ventilation or recovery time between patients — not standard surgical masks alone.

1. Is high-volume evacuation used consistently during aerosol-generating procedures? — Consistent use, not reserved for occasional cases.

2. Is respiratory protection appropriate to aerosol exposure used, not a standard surgical mask alone? — A specific, higher level of protection matched to genuine aerosol risk.
3. Is there a defined recovery time or ventilation standard between patients in the same treatment space? — A specific, followed interval, not an assumption the air clears quickly enough.

8.3 Every Dental X-Ray Is Justified, Not Routine

Non-Negotiable

Every dental radiograph is individually justified by clinical need, not taken as a routine default, with dose kept as low as reasonably achievable and equipment subject to regular quality control.

1. Is each radiograph justified by a specific clinical reason, documented, not taken as a routine default for every visit? — A specific, recorded clinical reason for this patient, this visit.
2. Is prior imaging reviewed before ordering a new radiograph, to avoid unnecessary repeat exposure? — Checking existing images first, not defaulting to a new exposure.
3. Is X-ray equipment subject to regular quality control and calibration? — Verified equipment performance, not assumed from the image looking acceptable.

8.4 Extraction and Surgical Consent Covers Real, Procedure-Specific Risk

Non-Negotiable

Consent for extraction or other invasive dental procedures includes a genuine conversation about procedure-specific risks — infection, prolonged bleeding, nerve involvement where relevant — not a generic consent form covering "dental treatment" broadly.

1. Does consent for an invasive procedure specifically name that procedure's real risks, not a generic "dental treatment" consent? — Named, specific risks for this specific procedure.
2. Can the patient explain back what the specific procedure involves and its main risks? — Tests genuine understanding, not just a signature.
3. Where nerve involvement or other procedure-specific risk is relevant, is it specifically discussed? — Named directly, not folded into a general risk statement.

8.5 Amalgam Waste Is Captured and Disposed of Correctly

Non-Negotiable

Where dental amalgam is used, a compliant amalgam separator captures waste before it enters the wastewater stream, and all amalgam waste is collected and forwarded to a licensed recycler, not discharged or discarded as general waste.

1. Is a compliant amalgam separator installed and functioning wherever amalgam is used or removed? — Installed and genuinely functioning, not present but bypassed or unmaintained.
2. Is all amalgam waste — capsules, chairside traps, extracted teeth with amalgam — collected and forwarded to a licensed recycler? — All amalgam waste categories, not only the most visible one.
3. Is the amalgam separator maintained and replaced on the manufacturer's recommended schedule? — A separator that isn't maintained loses its capture effectiveness over time.

STANDARD 9

Aesthetic & Injectable Medicine

9.1 A Licensed Physician Oversees Every Injection, Even If Not the Injector

Non-Negotiable

A licensed physician holds genuine, documented oversight of every injectable procedure performed at this facility, whether or not the physician personally administers each injection — not an arrangement where trained staff inject with no real physician accountability.

1. Is there a specific, named licensed physician with documented oversight of injectable procedures here? — A specific person and a real, checkable oversight relationship, not an assumed general affiliation.

2. If a non-physician performs the injection, is the physician's oversight genuine and immediate, not remote or after the fact? — Real-time availability and accountability, not a signature reviewed days later.
3. Can the physician describe their actual involvement in a recent case, specifically? — A real, specific example, not a general description of the arrangement.

9.2 Injectable Products Are Sourced From Verified, Traceable Suppliers

Non-Negotiable

Every injectable product used is sourced from a verified, traceable supplier, with batch and lot records retained — not purchased through unverified channels where authenticity cannot be confirmed.

1. Is every injectable product sourced from a verified, traceable supplier, not an unverified or informal channel? — A checkable, legitimate supply chain, not just a lower price.
2. Are batch and lot numbers retained for every product used, linked to the patient record? — Traceability that would allow a recall or adverse event investigation to actually work.
3. Can staff describe how they'd recognise a counterfeit or suspicious product? — Genuine awareness, not an assumption that sourcing alone guarantees authenticity.

9.3 Vascular Occlusion Is Recognised and Treated Within Minutes, Not Hours

Non-Negotiable

Staff performing filler injections are specifically trained to recognise the signs of vascular occlusion immediately, with hyaluronidase or the appropriate emergency treatment genuinely available on-site — not requiring the patient to be sent elsewhere before treatment can begin.

1. Are staff specifically trained to recognise the early signs of vascular occlusion during and immediately after injection? — Specific, trained recognition, not general awareness that complications exist.
2. Is hyaluronidase, or the appropriate treatment for the products used, genuinely available on-site, not requiring off-site sourcing? — Immediately available, not something ordered after a complication is recognised.
3. Is there a defined, immediate escalation process if a suspected occlusion doesn't respond to initial treatment? — A specific next step, not uncertainty about what happens if first-line treatment isn't enough.

9.4 Patients Are Screened for Genuine Medical Suitability Before Treatment

Core

Every patient undergoes a genuine medical suitability screening before treatment — relevant medical history, medications, prior reactions — not a booking process that moves directly from consultation to injection with no real screening step.

1. Does every patient undergo a genuine medical suitability screening before treatment, not just a booking conversation? — A real, structured screening step, not an informal chat covering only what the patient happens to mention.
2. Does screening specifically cover relevant medications, prior reactions, and medical conditions that change risk? — Specific, relevant questions, not a generic intake form.
3. Where screening identifies a relevant risk factor, does this genuinely change the treatment decision? — Screening that never changes an outcome isn't providing real protection.

STANDARD 10

Longevity & IV Therapy

10.1 IV Line Insertion and Site Care Follow Recognised Infusion Standards

Non-Negotiable

IV line insertion, site selection, and ongoing site care follow a recognised, evidence-based infusion therapy standard — aseptic technique, appropriate site selection, and defined site monitoring — not informal practice varying by whoever happens to be inserting the line.

1. Does IV insertion follow a recognised aseptic technique standard, applied consistently by every staff member who inserts lines? — A recognised standard, applied consistently — not technique that varies by individual.
2. Is the insertion site selected and assessed against defined criteria, not simply whichever vein is easiest to access? — Site selection based on vessel health and treatment need, not convenience alone.
3. Is the IV site monitored on a defined schedule for signs of complication, with a specific response if found? — A defined monitoring schedule and response, not informal checking.

10.2 Hormone and Peptide Products Are Sourced From Licensed, Regulated Suppliers Only

Non-Negotiable

Every hormone, peptide, or compounded product used is sourced exclusively from a licensed, regulated compounding or manufacturing facility recognized by the relevant national medicines regulatory authority — never from research-use-only vendors, overseas suppliers, or any source without verifiable regulatory standing, regardless of cost or convenience.

1. Is every hormone or peptide product sourced from a licensed, regulated compounding or manufacturing facility, verifiable by name? — A specific, named, licensed source — not "we have a supplier."
2. Are research-use-only or overseas-sourced products genuinely excluded, not used under a different label? — Genuine exclusion, not the same product relabelled or described differently.
3. Does documentation retain certificates of analysis or equivalent verification for products used? — Real, retained verification, not assumed from the supplier's reputation alone.

10.3 Physician Oversight of Hormone and Peptide Protocols Is Genuine, Not Nominal

Non-Negotiable

A licensed physician genuinely evaluates and prescribes each patient's specific hormone or peptide protocol, based on that patient's actual results and history — not a standardised protocol applied uniformly with a physician's name attached after the fact.

1. Does a licensed physician genuinely evaluate each patient individually before prescribing a hormone or peptide protocol? — A real, individual clinical evaluation, not a standard protocol applied to everyone.
2. Is the protocol adjusted based on this specific patient's actual monitoring results, not applied uniformly regardless of results? — Genuine responsiveness to this patient's data.
3. Can the physician describe their specific reasoning for a particular patient's protocol? — Real, individual clinical reasoning, not a general description of the standard approach.

10.4 Baseline Screening Happens Before Any Protocol Begins, Not After

Core

Every patient undergoes genuine baseline laboratory and clinical screening before a hormone or peptide protocol begins, with monitoring continuing at defined intervals — not a protocol started based on symptoms alone, with testing added only if a problem later emerges.

1. Does every patient undergo genuine baseline screening before any protocol begins, not after starting? — Testing before the first dose, not added only if a concern later arises.
2. Is monitoring continued at defined intervals throughout the protocol, not only at baseline? — A specific, followed monitoring schedule, not a one-time check.
3. Are monitoring results actually reviewed and acted on, not just filed? — Genuine review that can change the protocol, not passive data collection.

STANDARD 11

Oncology & Infusion Therapy

11.1 Cytotoxic Drug Handling Follows a Verified Safe-Handling Standard

Non-Negotiable

Preparation, administration, and disposal of cytotoxic and other hazardous drugs follows a defined, verified safe-handling standard — appropriate personal protective equipment, engineering controls, and disposal procedures — not informal practice that varies by individual staff member.

1. Is appropriate personal protective equipment — including chemotherapy-rated gloves and gowns — used consistently for every stage of handling? — Consistent use at every stage, not only during administration.
2. Are hazardous drugs prepared and stored using the required engineering controls, not standard pharmacy equipment? — Specific, required controls, not general pharmacy practice assumed to be sufficient.
3. Is hazardous waste disposed of through a defined, compliant pathway, not general medical waste? — A specific, separate disposal pathway matched to the actual risk.

11.2 Chemotherapy Dose Is Verified by Independent Two-Person Check

Non-Negotiable

Every chemotherapy dose, drug, route, and infusion rate is independently verified by two qualified individuals before administration, each forming their own judgement separately — not a single check followed by a second signature.

1. Does every chemotherapy dose undergo independent verification by two qualified individuals before administration? — Two people, every dose, without exception for perceived routine cases.
2. Does each person form their own separate judgement, not simply confirm the first person's check? — Genuine independence, not sequential confirmation of the same conclusion.
3. Does verification specifically cover drug, dose, route, and infusion rate together, not dose alone? — All four elements, since an error in any one carries real risk.

11.3 Extravasation Is Recognised and Managed Immediately

Non-Negotiable

Staff administering vesicant or irritant chemotherapy agents are specifically trained to recognise early signs of extravasation, with a defined, immediate management protocol and appropriate antidotes genuinely available on-site.

1. Are staff specifically trained to recognise early signs of extravasation for the agents actually used here? — Specific to the actual agents administered, not generic infusion complication awareness.
2. Is there a defined, immediate management protocol for suspected extravasation? — A specific, known protocol, not improvisation in the moment.
3. Are appropriate antidotes for the specific vesicant agents used genuinely available on-site? — Immediately available and in date, matched to the actual agents in use.

11.4 Infusion Reaction and Anaphylaxis Response Is Rehearsed, Not Theoretical

Non-Negotiable

Staff are trained and drilled — not only briefed — on recognising and responding to infusion reactions and anaphylaxis, with emergency medications and equipment genuinely available at the point of infusion, verified through a real, practiced response, not a written plan alone.

1. Have staff actually rehearsed an infusion reaction and anaphylaxis response, not only reviewed a written protocol? — A genuine drill, not a policy document read once.
2. Are emergency medications and equipment genuinely available at the point of infusion, not in a separate location requiring retrieval? — Immediately at hand, not requiring travel to another room during an emergency.

3. Do all staff present during infusions know their specific role in a reaction response, not just that a protocol exists? — Specific, assigned roles, not general awareness.

STANDARD 12

Dialysis & Renal Replacement Therapy

12.1 Dialysis Water Treatment Meets a Verified Quality Standard

Non-Negotiable

Water used to prepare dialysis fluid meets defined chemical and microbiological quality requirements, verified through regular testing against a recognised international standard — not assumed safe because it passes through a treatment system.

1. Is dialysis water tested against the specific chemical and microbiological limits set by the recognised standard, not general water safety limits? — Dialysis-specific limits, which are meaningfully stricter than general drinking water standards.
2. Is testing conducted on a defined, regular schedule, with results reviewed and acted on? — Regular, scheduled testing with genuine review, not occasional or reactive testing.
3. Is there a defined response if a test result exceeds the allowable limit? — A specific action, not uncertainty about what happens when a limit is exceeded.

12.2 Vascular Access Site Care Follows Recognised Core Interventions

Non-Negotiable

Vascular access care and catheter accessing follow a defined set of core infection prevention interventions — aseptic technique, hub disinfection, and structured surveillance — verified through periodic direct observation, not assumed from staff training alone.

1. Are the specific core interventions — surveillance, hand hygiene observation, vascular access care observation — all actively followed, not only some of them? — All core interventions together, not a partial selection.
2. Is vascular access care and catheter accessing technique directly observed on a defined schedule, not assumed from training? — Direct observation, at least quarterly, not reliance on initial training alone.
3. Is infection surveillance data calculated and actively shared with front-line clinical staff, not filed without review? — Genuine sharing that could influence practice, not passive record-keeping.

12.3 Patients Are Monitored for Intradialytic Complications Throughout

Non-Negotiable

Patients are actively monitored throughout the dialysis session for signs of intradialytic complications — hypotension, cramping, access-related bleeding — on a defined schedule, not checked only at the start and end of the session.

1. Are patients monitored at defined intervals throughout the entire session, not only at start and end? — Monitoring spread across the full session duration, not concentrated at the edges.
2. Does monitoring specifically include blood pressure, access site, and patient-reported symptoms together? — All three together, since each can reveal a different type of developing complication.
3. Is there a defined, immediate response if monitoring identifies a possible complication? — A specific, known response, not improvisation in the moment.

12.4 Reuse or Single-Use Policy for Dialyzers Is Explicit and Followed

Non-Negotiable

The facility has an explicit, written policy on whether dialyzers are single-use or reprocessed for reuse, with the actual practice matching the written policy, and any reprocessing following a defined, verified protocol — not an informal practice that varies without a stated policy.

1. Does the facility have an explicit, written policy stating whether dialyzers are single-use or reprocessed? — A specific, written policy, not an informal, undocumented practice.
2. Does actual practice match the written policy, verified directly, not assumed? — Genuine consistency between stated policy and real practice.
3. Where reprocessing occurs, does it follow a defined, verified protocol, including water quality specific to reprocessing? — A specific, verified protocol, not informal reprocessing practice.

STANDARD 13

Fertility & IVF

13.1 Embryology Lab Quality Control Is Verified, Not Assumed

Non-Negotiable

Embryo and oocyte assessment follows a recognised international consensus standard, with laboratory conditions — temperature, air quality, incubator calibration — verified through defined, regular quality control, not assumed stable because equipment appears to be functioning.

1. Does embryo and oocyte assessment follow a recognised international consensus standard, applied consistently? — A named, recognised standard, applied by every embryologist consistently.
2. Are laboratory conditions — temperature, air quality, incubator calibration — verified through defined, regular quality control? — Regular, scheduled verification, not assumed from equipment appearing to function.
3. Is there a defined response if quality control identifies conditions outside acceptable range? — A specific action, not uncertainty about what happens when a reading is out of range.

13.2 Hormone Stimulation Protocols Have Real, Documented Physician Oversight

Non-Negotiable

Ovarian stimulation protocols are individually determined and monitored by a licensed physician based on this specific patient's response, following recognised clinical guidance — not a standardised protocol applied uniformly regardless of individual monitoring results.

1. Is the stimulation protocol individually determined for this specific patient, not a standard protocol applied uniformly? — A real, individual clinical decision, reflecting this patient's own profile.
2. Is the protocol adjusted based on this patient's actual monitoring results during stimulation? — Genuine responsiveness to real-time monitoring data, not a fixed plan followed regardless.
3. Is there a defined process for recognising and managing ovarian hyperstimulation syndrome risk specifically? — A specific, known process for this specific serious risk, not general awareness alone.

13.3 Multiple-Pregnancy Risk Is Explicitly Discussed Before Transfer

Core

Before every embryo transfer, the patient has a genuine, documented conversation about multiple-pregnancy risk specific to the number of embryos being considered, including the option of single embryo transfer — not a generic consent form covering "embryo transfer" without this specific discussion.

1. Does every patient have a specific, documented conversation about multiple-pregnancy risk before transfer? — A specific conversation about this risk, not folded into general transfer consent.
2. Is single embryo transfer genuinely presented as an option, not just multiple-embryo transfer as the default? — A genuine choice presented, not a default the patient would need to actively push back against.
3. Can the patient explain back the specific risk relevant to their own transfer decision? — Tests genuine understanding, not just that a conversation occurred.

13.4 High-Stakes Consent Reflects the Real Emotional and Financial Weight of the Decision

Core

Consent conversations for fertility treatment genuinely address the real emotional and financial weight of the decision — realistic success rates specific to this patient, not generic clinic statistics, and the real possibility of an unsuccessful cycle — not a form focused only on the physical procedure.

1. Does consent include realistic success rates specific to this patient's own profile, not generic clinic-wide statistics? — Individualised, honest expectations, not marketing-oriented general figures.
2. Is the real possibility of an unsuccessful cycle genuinely discussed, not treated as an unlikely exception? — Honest acknowledgement, not an implicit assumption of success.
3. Does the conversation address the real financial commitment, including the possibility of multiple cycles? — Genuine financial transparency, not deferred until costs are already being incurred.

13.5 A Witnessing Protocol Prevents Gamete and Embryo Mix-Up

Non-Negotiable

Every critical step involving gamete or embryo handling — collection, insemination, cryopreservation, thaw, transfer — is verified through a defined witnessing protocol, either double manual witnessing by a second qualified person or a certified electronic witnessing system, with every step traceable.

1. Is every critical step — collection, insemination, cryopreservation, thaw, transfer — covered by a defined witnessing protocol? — Every critical step specifically, not a general awareness of the importance of care.
2. Is witnessing genuinely independent — a second qualified person or certified electronic system — not the same person self-confirming? — Genuine independence, whether human or verified electronic system.
3. Is every witnessed step traceable after the fact, with a retained record of who witnessed what and when? — A real, retained record, not an assumption that witnessing happened because the protocol exists.

STANDARD 14

Cardiology & Cardiac Catheterization

14.1 Contrast Media Reaction Response Is Rehearsed, Not Theoretical

Non-Negotiable

Staff are trained and drilled — not only briefed — on recognising and managing contrast media hypersensitivity reactions, with a risk-based premedication and management approach for patients with prior reaction history, and emergency treatment genuinely available at the point of contrast administration.

1. Have staff actually rehearsed a contrast reaction response, not only reviewed a written protocol? — A genuine drill, not a policy document read once.
2. Does the facility's approach to prior-reaction patients reflect current, evidence-based guidance, not outdated assumptions? — Current practice, specifically checked against recent guidance updates.
3. Is emergency treatment for anaphylaxis genuinely available at the point of contrast administration, not in a separate location? — Immediately at hand, not requiring retrieval during an emergency.

14.2 Vascular Access Site Complications Are Actively Monitored

Non-Negotiable

Patients are monitored for vascular access site complications — bleeding, hematoma, pseudoaneurysm — on a defined schedule appropriate to the access site used, with staff specifically trained on the distinct complication patterns of the access site actually used for each patient.

1. Is monitoring specific to the actual access site used for each patient, not a generic approach applied regardless? — Site-specific monitoring, reflecting the genuinely different risk pattern of radial versus femoral access.
2. Are staff specifically trained to recognise complications distinct to each access site type used at this facility? — Specific training matched to the access types actually used, not general awareness.
3. Is monitoring conducted on a defined schedule appropriate to the access site, with findings documented? — A specific, followed schedule, not informal or inconsistent checking.

14.3 Radiation Exposure to Patients and Staff Is Tracked and Limited

Non-Negotiable

Radiation dose to both patients and staff is tracked per procedure, using ALARA-consistent technique to minimise exposure, with cumulative staff exposure monitored against recognised occupational limits — not managed only by general awareness that radiation exposure matters.

1. Is patient radiation dose tracked per procedure, with the data reviewed, not just generated and filed? — Genuine tracking and review, not data collected without ever being examined.
2. Are ALARA-consistent technique practices — collimation, appropriate frame rate, distance optimisation — genuinely applied, not just known about? — Applied in actual practice, not simply familiar concepts.
3. Is cumulative staff radiation exposure monitored against recognised occupational limits, with dosimetry genuinely worn and reviewed? — Real, worn dosimetry with genuine review, not badges issued but not consistently used or checked.

STANDARD 15

Ophthalmology & Day Surgery

15.1 Endophthalmitis Prevention Protocol Is Followed Precisely, Not Approximately

Non-Negotiable

Cataract and other intraocular procedures follow a precise, evidence-based endophthalmitis prevention protocol — specific povidone-iodine antiseptics timing and intracameral antibiotic use — verified as actually followed to the letter, not approximated or applied loosely.

1. Is povidone-iodine antiseptics applied with the specific, evidence-based timing — not just used generally at some point before surgery? — A specific timing protocol, not general antiseptic use approximated by feel.
2. Is intracameral antibiotic prophylaxis used at the specific dose supported by evidence, prepared correctly to avoid dilution error? — The specific, evidence-supported approach, prepared with genuine care against a known error risk.
3. Is the actual protocol followed verified periodically, not assumed from the fact that a protocol exists? — Genuine verification, not an assumption that a written protocol is automatically followed precisely.

15.2 Surgical Consent Covers Realistic Outcome Expectations, Not Just Risk

Core

Consent for cataract and refractive procedures includes a genuine, honest discussion of realistic outcome expectations — including the real possibility of needing glasses afterward, or less than perfect vision — not only a list of physical risks with success implicitly assumed.

1. Does consent genuinely discuss realistic visual outcome expectations, not only physical risks? — A real discussion of what vision will likely be like afterward, not just what could go wrong.
2. Is the real possibility of still needing glasses, or less than perfect vision, explicitly discussed? — Honest, specific discussion, not an assumption of a perfect outcome.
3. Can the patient explain back realistic expectations for their own specific case? — Tests genuine understanding specific to this patient, not general awareness that outcomes vary.

15.3 Post-Procedure Vision Is Checked Before Discharge, Not Assumed Stable

Non-Negotiable

Every patient undergoes a genuine post-procedure vision and eye check before discharge, with specific criteria for what triggers extended observation or same-day escalation — not discharged based on general appearance or the patient simply feeling ready to leave.

1. Does every patient undergo a genuine, specific vision and eye check before discharge, not a general assessment of how they seem? — A specific clinical check, not a general impression.
2. Are there specific, defined criteria for what would trigger extended observation or escalation? — Specific, known criteria, not a vague sense that something seems off.
3. Is the check performed by someone specifically qualified to recognise early signs of complication? — A qualified assessor, not whoever happens to be available at discharge time.

STANDARD 16

Diagnostic Imaging

16.1 CT Radiation Dose Is Tracked and Benchmarked, Not Just Delivered

Non-Negotiable

CT radiation dose is tracked per examination and periodically benchmarked against recognised national or international diagnostic reference levels, with protocols reviewed and adjusted when dose consistently runs high — not delivered and filed with no comparison to any external standard.

1. Is radiation dose tracked for every CT examination, not only sampled occasionally? — Consistent tracking for every examination, not periodic spot-checking alone.
2. Is facility dose data periodically compared against a recognised external benchmark, not only reviewed internally? — A real external reference point, not only comparison against the facility's own historical data.
3. When dose consistently runs high against the benchmark, is the protocol actually reviewed and adjusted? — Genuine review leading to action, not benchmarking data collected without consequence.

16.2 MRI Safety Screening Happens Before Every Scan, Not Assumed From Intake

Non-Negotiable

Every patient undergoes a genuine, verbal MRI safety screening immediately before entering the scan room, reviewing a completed written questionnaire in full — not relying on an intake form completed earlier and never actively reviewed at the point of the actual scan.

1. Does every patient undergo a genuine verbal screening review immediately before entering the scan room, not only earlier intake screening? — A real, verbal review at the actual point of entry, not reliance on an earlier form alone.
2. Is the full written questionnaire reviewed in its entirety, not just a quick verbal confirmation? — Complete review of every question, not an abbreviated check.
3. Are patients specifically asked to remove jewellery, metallic clothing items, and similar objects immediately before the scan? — A specific, direct check, not an assumption the patient already did this.

16.3 Contrast Media Protocols Match the Same Standard Used Elsewhere in This Facility

Core

Where imaging uses contrast media, the reaction recognition and management protocol is identical to the one used elsewhere in this facility for the same purpose — not a separate, independently developed protocol that may have quietly diverged from current guidance.

1. Is the contrast reaction protocol used in imaging identical to the one used elsewhere in this facility, not independently maintained? — A genuinely shared, single protocol, not two versions that happen to be similar.

2. When the shared protocol is updated, does imaging's version update at the same time, not lag behind? — Synchronised updates, not a separate update cycle for each department.
3. Are staff in imaging trained on the same protocol version as staff elsewhere in the facility? — Consistent training content, not department-specific variations.

STANDARD 17**Dermatology****17.1 Biopsy Specimens Are Tracked to a Confirmed Pathology Result****Non-Negotiable**

Every skin biopsy is tracked from collection through to a confirmed, communicated pathology result, with a specific, named process ensuring no specimen result goes unreviewed or unreported to the patient — distinct from, and more specifically tracked than, general test results.

1. Is there a specific, named tracking process for biopsy specimens, distinct from general test result tracking? — A dedicated process specifically for biopsies, given the distinct severity risk.
2. Is there a way to identify a biopsy specimen whose result was never actually received or reviewed? — An active mechanism that surfaces a gap, not one that only shows completed results.
3. Is the confirmed result specifically communicated to the patient, with the communication itself tracked? — Tracked communication, not an assumption the patient was informed because the result exists in the chart.

17.2 Cryotherapy and In-Office Procedures Follow a Defined Safety Protocol**Non-Negotiable**

Cryotherapy and other in-office dermatological procedures follow a defined protocol for technique, treatment depth appropriate to the lesion, and post-procedure care instruction — not applied based on individual practitioner habit without a documented, consistent standard.

1. Does the practice follow a defined protocol for technique and treatment depth matched to lesion type? — A specific, documented protocol, not individual practitioner habit alone.
2. Is there a documented process for confirming a lesion's suitability for cryotherapy before treating, rather than a suspicious lesion being frozen without biopsy consideration? — A specific decision point, not automatic treatment without considering whether biopsy is warranted first.
3. Is post-procedure care instruction given consistently, specific to the procedure performed? — Consistent, procedure-specific instruction, not generic aftercare advice.

17.3 Phototherapy Dosing Follows Evidence-Based Protocol, Not Estimation**Non-Negotiable**

UV phototherapy dosing is based on minimal erythema dose testing or a defined skin-phototype protocol, with dose adjustment following specific, evidence-based rules based on erythema response — not estimated by practitioner judgement without a documented dosing framework.

1. Is initial phototherapy dose based on minimal erythema dose testing or a defined skin-phototype protocol? — A specific, evidence-based starting point, not an estimated or arbitrary initial dose.
2. Does dose adjustment follow specific, defined rules based on the patient's actual erythema response? — A specific rule set, not practitioner judgement applied inconsistently.
3. Is cumulative UV exposure tracked over the course of treatment, not just each session's dose in isolation? — Tracked cumulative exposure, since total lifetime UV exposure carries its own real, distinct risk.

17.4 Suspicious Lesions Have a Defined, Timed Escalation Path**Non-Negotiable**

A lesion with suspicious features has a defined, timed escalation path — biopsy timeframe, referral pathway for advanced management — verified as actually followed, not left to case-by-case urgency judgement without a specific standard.

1. Is there a specific, defined timeframe for biopsying a lesion identified as suspicious, not routine scheduling? — A specific, known timeframe, not folded into normal appointment availability.
2. Is there a defined referral pathway to advanced management when findings warrant it? — A specific, named pathway, not a general intention to refer if needed.
3. Is adherence to the escalation timeframe actually tracked, not assumed from the pathway existing on paper? — Genuine tracking of actual timeframes achieved, not an assumption the pathway is followed.

STANDARD 18

Allergy & Immunotherapy

18.1 Post-Injection Observation Time Is Enforced, Not Assumed

Non-Negotiable

Every patient receiving an allergen immunotherapy injection is observed on-site for the minimum required period afterward, with this actually enforced — not left to the patient's own judgement about whether they feel well enough to leave early.

1. Is the minimum observation period actually enforced for every patient, not left to the patient's own judgement? — Genuinely enforced, not a recommendation the patient can opt out of by feeling ready to leave.
2. Is the patient's departure time actually recorded and compared against injection time? — A real, checkable record, not an assumption the full period was observed.
3. Is there a specific process for extending observation if symptoms develop during the standard window? — A defined, known extension process, not uncertainty about what happens if something develops.

18.2 Dose Escalation Follows a Defined, Individualized Schedule

Non-Negotiable

Immunotherapy dose escalation follows a defined schedule, individually adjusted for missed doses, prior reactions, and known risk factors — not advanced automatically according to a fixed calendar regardless of what actually happened at the previous visit.

1. Is dose escalation adjusted for missed doses, not advanced automatically as if the prior visit occurred on schedule? — A specific, defined adjustment rule for missed doses, not automatic progression.
2. Is dose escalation adjusted based on any reaction at the prior dose, not proceeding regardless? — Genuine responsiveness to prior reaction history for this specific patient.
3. Is the current dose and escalation status verified before each injection, not assumed from the calendar? — An active check against the patient's actual record, not assumed from how much time has passed.

18.3 Extract Preparation and Labeling Prevents Vial Mix-Up

Non-Negotiable

Allergen extract preparation, dilution, and labeling follows a defined, verified process specifically designed to prevent vial mix-up between patients — with a genuine, independent check before administration confirming the correct vial for the correct patient.

1. Is there a defined process for preparing and labeling extract vials that specifically prevents mix-up between patients? — A specific, designed process, not general care assumed to be sufficient.
2. Is there a genuine, independent check confirming the correct vial for the correct patient before administration, distinct from general patient identification? — A specific vial-to-patient check, not folded into or assumed covered by general identification.
3. Are vials specifically labeled with concentration and patient identity in a way that's checked, not just present? — Genuinely checked labeling, not assumed correct because a label exists.

STANDARD 19**Plastic & Cosmetic Surgery****19.1 VTE Risk Is Assessed Using a Validated Score, Completed by the Physician****Non-Negotiable**

Every patient undergoing a procedure under general anesthesia lasting over 60 minutes has a validated venous thromboembolism risk score completed by the physician, not the patient, with prophylaxis decided according to the resulting risk category — not assumed low-risk because the patient appears otherwise healthy.

1. Is a validated VTE risk score completed by the physician, not the patient, for every applicable procedure? — Physician-completed specifically, not relying on patient self-report.
2. Does the resulting risk category actually determine the prophylaxis decision, not just get recorded and set aside? — Genuine, documented decision-making tied to the score, not a score calculated but not acted on.
3. Is the risk score specifically re-assessed if the planned procedure changes in scope or duration? — Reassessment reflecting the actual procedure performed, not the originally planned one.

19.2 Office-Based Anesthesia Follows Defined Safety Standards**Non-Negotiable**

Anesthesia administered in an office-based surgical setting follows the same defined safety standards as a hospital operating room — qualified personnel, appropriate monitoring equipment, and a defined emergency transfer protocol — not a reduced standard justified by the office setting.

1. Is anesthesia administered by personnel with qualifications equivalent to a hospital operating room standard? — The same qualification standard, not a reduced one for the office setting.
2. Is monitoring equipment equivalent to what a hospital operating room would use for the same procedure? — Genuinely equivalent equipment, not a scaled-down version.
3. Is there a specific, defined emergency transfer protocol to a hospital, with a named receiving facility? — A specific, real protocol and named facility, not a general assumption that transfer would happen if needed.

19.3 Patient Selection Excludes Those Outside Safe Office-Based Surgery Criteria**Non-Negotiable**

Patient selection for office-based procedures follows specific, defined exclusion criteria — BMI thresholds, relevant comorbidities, combined procedure duration limits — verified before scheduling, not assessed only on the day of surgery when declining is far harder.

1. Are specific exclusion criteria for office-based surgery defined and applied before scheduling, not only assessed the day of surgery? — Pre-scheduling assessment, catching an issue before the patient has already prepared and arrived.
2. Do the criteria specifically address BMI thresholds, relevant comorbidities, and combined procedure duration limits? — Specific, named factors, not a general clinical judgement standard.
3. Is there a real, documented example of a patient being declined or redirected to a hospital setting based on these criteria? — A real example demonstrates the criteria have genuine teeth, not just theoretical existence.

STANDARD 20**Psychiatry & Mental Health**

20.1 Suicide Risk Screening Uses a Validated Tool, Applied Consistently

Non-Negotiable

Every patient is screened for suicide risk using a validated, unmodified screening tool, with a documented, evidence-based follow-up process for anyone who screens positive — not an informal clinical impression in place of a structured, consistent process.

1. Is every patient screened using a validated tool, administered without informal changes to its wording? — The tool exactly as validated, not adapted or shortened informally.
2. Does a positive screen trigger a defined, evidence-based follow-up assessment, not just a note in the chart? — A genuine, structured next step, not passive documentation alone.
3. Is the documented risk level tied to a specific, written mitigation plan for that patient? — A real, individual plan, not a generic statement that risk was assessed.

20.2 Psychiatric Medication Management Follows a Defined Interaction and Monitoring Protocol

Non-Negotiable

Psychiatric medication prescribing follows a defined process for checking interactions specific to psychotropic combinations, with required baseline and ongoing monitoring completed and reviewed — not prescribed based on symptom response alone, without the monitoring psychotropic medications specifically require.

1. Is there a defined process for checking interactions specific to psychotropic medication combinations? — A specific process for this medication class, not general interaction checking alone.
2. Is required baseline monitoring completed before starting medications that specifically require it? — Genuine baseline testing before starting, not added only if a concern later emerges.
3. Is ongoing monitoring completed and reviewed at the required intervals, not only at symptom-focused visits? — A defined, followed monitoring schedule, distinct from routine symptom check-ins.

20.3 Crisis Escalation Has a Defined, Immediate Pathway to Higher Level of Care

Non-Negotiable

Staff have a defined, immediate escalation pathway for a patient in acute crisis, with a specific, named receiving facility for emergency psychiatric care, verified as genuinely functioning — not a general understanding that emergency services would be contacted if needed.

1. Is there a specific, defined escalation pathway for a patient in acute crisis, not general awareness that help exists? — A specific, known pathway, not improvisation in the moment.
2. Is there a specific, named receiving facility for emergency psychiatric care? — A specific facility and relationship, not a general assumption somewhere would take the patient.
3. Do all clinical staff, not only the most senior, know the specific escalation steps confidently? — Genuine, distributed readiness, not knowledge held only by the most experienced person present.

STANDARD 21

Narcology & Addiction Treatment

21.1 Controlled Substance Handling Follows a Defined Diversion Control Plan

Non-Negotiable

Storage, dispensing, and any take-home provision of controlled medications used in addiction treatment follows a specific, written diversion control plan — secure storage, dispensing records, identifiable take-home packaging — not general good practice without a defined, documented plan.

1. Is there a specific, written diversion control plan covering storage, dispensing, and take-home provision? — A specific, documented plan, not general good practice assumed to be sufficient.

2. Is take-home medication packaged and labeled in a way specifically designed to identify it and deter diversion? — Specific, identifiable packaging, not standard containers without distinguishing features.
3. Do patients receiving take-home medication receive specific education on safe storage and transport, including household safety? — Genuine, documented education, not assumed common sense.

21.2 Withdrawal Management Uses a Validated Assessment Scale, Not Clinical Impression Alone

Non-Negotiable

Withdrawal severity is assessed using a validated, standardised scale, applied consistently and at defined intervals, with the result actively guiding the management decision — not estimated from clinical impression without a structured, repeatable tool.

1. Is a validated, standardised withdrawal assessment scale used consistently, not clinical impression alone? — A specific, validated tool, applied the same way every time.
2. Is the scale applied at defined intervals appropriate to the withdrawal risk, not only when a concern happens to arise? — A specific, scheduled interval, not reactive assessment alone.
3. Does the scale result actually guide the management decision, not just get recorded alongside a separately made clinical decision? — Genuine, documented linkage between score and decision, not parallel, disconnected processes.

21.3 Urine Drug Screening Chain of Custody Prevents Tampering

Core

Urine drug screening follows a defined chain-of-custody process — specimen temperature verification, direct observation where clinically indicated, secure transport — that genuinely prevents substitution or tampering, not a process that assumes good faith without verification.

1. Is specimen temperature verified immediately after collection, as a specific, documented step? — A specific, documented check, not assumed from general collection procedure.
2. Is direct observation used where clinically indicated, following a specific, defined standard for when it applies? — A specific standard for when observation is used, not inconsistent, ad hoc application.
3. Is chain of custody maintained and documented from collection through to result, with any break specifically flagged? — A genuinely unbroken, documented chain, with any gap specifically identified, not assumed intact.

STANDARD 22

Gastroenterology & Endoscopy

22.1 Endoscope Reprocessing Follows the Multisociety Guideline, With Documented Staff Competency

Non-Negotiable

Flexible endoscope reprocessing follows the current multisociety guideline in full — cleaning before high-level disinfection, model-specific manufacturer instructions, complete documentation of every step — with staff competency specifically assessed and documented before they are permitted to perform reprocessing independently.

1. Does reprocessing follow a written policy matching the current multisociety guideline, including model-specific manufacturer instructions? — A specific, current, written policy, not general infection-control practice assumed to be sufficient.
2. Is staff competency specifically assessed and documented before they perform reprocessing independently? — Assessed competency before independent practice, not assumed from general training.
3. Is every reprocessing step documented for every instrument, creating a genuine, traceable record? — Complete, traceable documentation, not partial or assumed record-keeping.

22.2 Procedural Sedation Monitoring Follows Defined Standards

Non-Negotiable

Patients receiving procedural sedation for endoscopy are monitored using continuous pulse oximetry and capnography, with vital signs recorded at defined intervals and specific, defined discharge criteria met before release — not monitored informally or released based on general appearance alone.

1. Is continuous pulse oximetry and capnography used for every patient receiving procedural sedation? — Continuous, objective monitoring, not periodic spot-checking.
2. Are vital signs recorded at defined intervals throughout the procedure and recovery, not only at the start and end? — Consistent, scheduled recording throughout, not concentrated at the edges.
3. Are specific, defined discharge criteria met and documented before a patient is released, not judged from general appearance? — A specific, validated criteria set, not a subjective impression the patient seems ready.

22.3 Biopsy and Polyp Specimens Are Tracked to a Confirmed Pathology Result

Non-Negotiable

Every biopsy or removed polyp specimen is tracked from collection through to a confirmed, communicated pathology result, with a specific, named process ensuring no specimen result goes unreviewed or unreported to the patient — distinct from, and more specifically tracked than, general test results.

1. Is there a specific, named tracking process for biopsy and polyp specimens, distinct from general test result tracking? — A dedicated process specifically for these specimens, given the distinct severity risk.
2. Is there a way to identify a specimen whose result was never actually received or reviewed? — An active mechanism that surfaces a gap, not one that only shows completed results.
3. Is the confirmed result specifically communicated to the patient, with the communication itself tracked? — Tracked communication, not an assumption the patient was informed because the result exists in the chart.

STANDARD 23

Pediatric Ambulatory Care

23.1 Weight-Based Dosing Uses an Accurate, Current Weight, Independently Verified

Non-Negotiable

Every weight-based medication dose is calculated from a current, accurately measured weight — not an estimated, parent-reported, or outdated weight — with the calculation itself independently verified by a second trained person before administration.

1. Is every weight-based dose calculated from a weight measured at this visit, not estimated or carried over from a prior visit? — A current, actually measured weight, not an estimate or an assumption it hasn't changed.
2. Is the dose calculation independently verified by a second trained person before administration? — Genuine, independent verification, not the same person confirming their own calculation.
3. Is there a specific, defined process if the calculated dose falls outside an expected range for the child's age or weight? — A specific, known response, not proceeding regardless because the calculation was technically completed.

23.2 Consent and Communication Are Structured for the Actual Decision-Maker

Non-Negotiable

Consent and key clinical communication are directed to the parent or legal guardian as the actual decision-maker, verified as the correct individual for this specific child, with age-appropriate communication to the child themselves as a distinct, additional step — not assumed from whoever accompanies the child to the visit.

1. Is the legal decision-making authority of the accompanying adult specifically verified, not assumed? — Genuine verification, not an assumption based on who happens to be present.
2. Is there a specific process for situations where the accompanying adult may not hold full decision-making authority? — A known, specific process, not uncertainty about how to proceed.
3. Does the child receive age-appropriate communication about their own care, distinct from parental consent? — A genuine, separate step for the child, not consent obtained from the parent alone with the child excluded from the conversation entirely.

23.3 Vaccination Records Are Verified Against the Current Schedule, Not Assumed Current

Non-Negotiable

Vaccination status is actively verified against the current recommended schedule at every visit, with any gap specifically identified and addressed — not assumed up to date because no concern was raised, or because the family reports the child is current.

1. Is vaccination status actively checked against the current recommended schedule at every visit, not only when specifically raised? — An active, routine check, not dependent on the visit's specific reason or family-initiated request.
2. Is family-reported vaccination status cross-checked against a documented record where one exists, not accepted without verification? — Genuine cross-checking against documentation, not accepted report alone.
3. When a gap is identified, is there a specific, defined process for addressing it, not just noting it? — A real, active response, not passive documentation of a known gap.

STANDARD 24

Medical Tourism

24.1 Pricing Transparency for International Patients

Non-Negotiable

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

1. Does every international patient receive a complete, written, all-inclusive estimate before booking travel? — Written and complete, not a verbal figure that leaves room to grow later.
2. Does the estimate cover commonly needed extras, not just the base procedure fee? — Genuinely all-inclusive, not a narrow quote that predictably grows.
3. Is there a specific process for handling a genuine, unforeseeable cost change once the patient has arrived? — A defined, transparent process, not an unexplained addition to the bill.

24.2 Remote Records Transfer to Home-Country Physician

Non-Negotiable

A complete, usable record of the care provided is genuinely transferred to the patient's home-country physician before or immediately after the patient departs — not left to the patient to request, translate, and forward themselves.

1. Is a specific, complete record handoff to the patient's home provider actually completed before or immediately after departure? — A genuine, completed handoff, not records that exist but were never actually transmitted or confirmed received.
2. Are records provided in a form the home provider can actually use — appropriate language, standard format? — Genuinely usable documentation, not technically provided but practically unusable.

3. Is there a specific process for the patient to reach this facility if a complication arises after returning home? — A specific, known contact pathway, not an assumption the patient would figure out how to reach someone.

24.3 Language Access for Foreign Patients

Non-Negotiable

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

1. Is a genuinely competent, trained interpreter used for consent, treatment discussion, and aftercare instructions? — Trained interpreter competency, not ad hoc bilingual staff pressed into service.
2. Is interpreter access arranged before the patient arrives, not improvised on the day? — Planned in advance, matched to the patient's actual language.
3. Can the patient explain back key consent and aftercare information in their own words? — Tests genuine understanding, not just that interpretation technically occurred.

24.4 Travel, Accommodation, and Logistics Coordination

Core

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

1. Does the facility provide or genuinely coordinate travel and accommodation support, not just a list of options? — Real coordination, not information the patient must act on entirely alone.
2. Is accommodation genuinely suitable for post-procedure recovery, not just conveniently located? — Suitability for actual recovery needs, not proximity alone.
3. Is there a specific point of contact for logistics problems during the patient's stay? — A specific, known contact, not an assumption the patient will manage independently.

24.5 Post-Return Complication Tracking

Non-Negotiable

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

1. Is there a specific, active process for tracking international patient outcomes after they return home, not just a generic courtesy call? — An active, structured process, not a single, easily-missed follow-up attempt.
2. Is there a specific pathway for a home-country physician to report a complication back to this facility? — A real, known pathway, not an assumption the physician would somehow know how to reach the facility.
3. Are tracked complications reviewed and used to inform practice, not just recorded? — Genuine learning from real outcomes, not passive record-keeping.

24.6 Visa and Embassy Support Documentation

Core

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

1. Does the facility provide the specific documentation needed for medical visa applications, correctly and promptly? — Specific, correct documentation matched to actual requirements, not generic paperwork.
2. Is documentation provided with enough lead time for realistic visa processing? — Genuine lead time, not documentation issued so late that delay becomes likely.
3. Is there a specific process for correcting a documentation error quickly if one is identified? — A specific, responsive process, not a slow, informal correction path.

24.7 International Patient Complaint and Redress Process

Non-Negotiable

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

1. Is there a specific complaint channel genuinely reachable from the patient's home country, not requiring physical presence? — Genuine remote accessibility, not a channel that functionally only works locally.
2. Is the complaint channel accessible in relevant languages, not only the local language? — Genuine language accessibility, not a barrier that excludes exactly the patients most likely to need it.
3. Is there real, documented evidence that complaints from returned patients are actually addressed? — Genuine follow-through, not a channel that exists but produces no real response.

24.8 Facilitators and Agents Are Verified, Not Assumed Legitimate

Non-Negotiable

Any medical tourism facilitator or agent referring patients to this facility is specifically verified — real business registration, a real, checkable track record — with the verification documented, not accepted based on the volume of patients they refer or how professional their marketing appears.

1. Is each facilitator or agent specifically verified for legitimate business registration and a checkable track record? — Genuine, specific verification, not accepted based on referral volume or marketing professionalism alone.
2. Is verification documented and periodically reconfirmed, not done once and assumed to remain valid indefinitely? — An active, periodically reconfirmed process, not a one-time check.
3. Is there a specific process for reviewing what a facilitator actually tells patients about this facility? — Active oversight of facilitator representations, not an assumption they accurately represent the facility.

24.9 Travel-Associated Infection Risk Protocol

Non-Negotiable

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

1. Are international patients specifically assessed for travel-associated infection risk, not treated identically to local patients? — A specific, distinct assessment step, not folded into or skipped within general intake.
2. Does the assessment account for the patient's specific country of origin and recent travel history? — Specific to this patient's actual journey, not a generic travel question.
3. Are appropriate precautions applied based on the assessment, not just documented without changing practice? — Genuine, applied precautions, not an assessment that doesn't change anything.

24.10 Post-Procedure Travel Timing and Venous Thromboembolism Risk

Non-Negotiable

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

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

STANDARD 25

Refugee & Migrant Health

25.1 Language and Communication Aids — Interpreters and Cultural Mediators

Non-Negotiable

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

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

25.2 People-Centred Care Adapted to Migration and Displacement Experience

Non-Negotiable

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

1. Is care genuinely adapted to a patient's migration and displacement experience, not delivered identically regardless of history? — Genuine adaptation, not a generic cultural-awareness statement.
2. Is trauma-informed practice genuinely applied, not just referenced as a principle? — Actual practice adaptation, not an assumption of general sensitivity.
3. Are staff aware of legal-status barriers to access that may affect this specific patient? — Specific awareness, not a general sense that barriers can exist.

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

Non-Negotiable

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

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

25.4 Collaborative Practice Across Health and Social Services

Core

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

1. Does the facility actively engage with relevant social support services, not treat health care in isolation? — Genuine, active engagement, not a general awareness that such services exist.
2. Does handover to another provider specifically include migration- and displacement-related context? — Specific inclusion of this context, not a generic clinical handover.
3. Are staff aware of specific local services relevant to this population, not just services generally? — Specific, current knowledge, not a vague sense that support services exist somewhere.

25.5 Evidence-Informed Care for Refugee and Migrant Populations

Core

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

1. Are staff aware of evidence-informed guidelines specific to refugee and migrant health where they exist? — Specific, current awareness, not general clinical knowledge assumed to be sufficient.
2. Do staff recognise where this population's health needs genuinely differ from the general population? — Genuine, specific recognition, not an assumption that general guidelines always apply equally.
3. Is practice adapted where population-specific evidence indicates a different approach is warranted? — Actual practice adaptation, not awareness without application.

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

Non-Negotiable

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

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

25.7 Legal Status Diversity Recognition

Core

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

1. Can staff name the specific legal status categories this facility actually serves? — Specific, named categories, not a general sense that "migrants" are served.
2. Does the facility avoid applying a single, uniform assumption about access rights across all statuses? — Genuine differentiation, not treating all categories identically.
3. Is there a specific process for verifying which category applies when it's genuinely unclear? — A real, defined process, not guesswork or assumption when status is ambiguous.

25.8 Care Is Documented and Provided Regardless of Immigration or Legal Status

Non-Negotiable

Care is provided and fully documented for every patient regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to patients without documented status.

1. Is the same standard of care applied and documented the same way regardless of a patient's immigration or legal status? — Genuinely equal treatment, not a lesser or informal standard for undocumented patients.
2. Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation? — Specific, documented training, not assumed understanding.
3. Is patient information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information? — The same confidentiality protection extended to every patient, without exception.

25.9 Cross-Border Continuity of Care

Core

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

1. Are patients actively supported to hold their own portable health record, not relying solely on this facility's internal system? — A genuine, patient-held record, not only an internal system the patient can't access elsewhere.
2. Is the patient-held record updated regularly, not provided once and left stale? — Genuine, ongoing updates, not a one-time document that quickly becomes outdated.
3. Is the record provided in a form usable across different health systems, not tied to this facility's specific format alone? — Genuinely portable format, not one that only makes sense within this facility's own system.

25.10 Follow-Up Systems Account for Housing and Contact Instability

Core

Follow-up and recall systems have a genuine alternative pathway for patients without a stable address or phone number — community organization contact, in-person scheduling at the next visit, or another real mechanism — not a system that silently fails for any patient whose contact information changes or doesn't exist in the expected form.

1. Is there a genuine alternative follow-up pathway for patients without a stable address or phone number? — A real, specific alternative, not an assumption the standard system will eventually work.
2. Does the system actively identify when standard contact methods have failed, rather than silently losing the patient from tracking? — Active identification of a failed contact attempt, not passive assumption contact succeeded.
3. Are community organizations or other real intermediaries used as a genuine alternative contact channel where appropriate? — A genuine, functioning relationship, not a theoretical option never actually used.