

Hospital Standards — Full Guidance

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 143 criteria.

17 standards · 143 criteria · Version 4.0

ASF STANDARDS · HOSPITAL · STANDARD 1

Standard 1 — Access & Arrival

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

CRITERIA IN THIS STANDARD

- 1.1 — Findable Before Arrival
 - 1.2 — Hospital Grounds and Territory Entrance
 - 1.3 — Physical Access, or a Real Plan
 - 1.4 — Emergency Entrance, Marked and Clear
 - 1.5 — Wayfinding Without Staff Dependence
-

1.1 Findable Before Arrival

NON-NEGOTIABLE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

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

COMMON FAILURE MODES

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

WORKED EXAMPLE

IN PRACTICE

A 120-bed regional hospital in a mid-sized city, on a street renamed three years ago.

BEFORE

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

ACTION

The Coordinator (1) claimed the Google Business listing and corrected the pin, address, phone and hours; (2) checked the website, the Ministry of Health directory, and the two main local directories and fixed each; (3) called each listed phone number from an outside line to confirm it rang and was answered; (4) added a quarterly check to the calendar.

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

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

2. Does the phone number listed actually connect to your facility when called? — *Tested directly, not assumed because it was correct when first published.*
Evidence: Call log or test record

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

to the wrong street in an emergency.

Evidence: Map screenshot

4. Is the range of services the facility actually provides published somewhere a prospective patient can find it before contacting the facility, and kept up to date as services change? — *Genuinely current public information, not a service list last updated years ago or only available by asking.*

Evidence: Website services page, publication date

COMMON REASONS FOR A PARTIAL ANSWER

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

IMPLEMENTATION PLAN

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

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Public search test	Independently searches for the facility exactly as a patient would — by name, address, phone number — using only public information.
DOCUMENT	Address cross-check	Confirms the mapped or listed address matches what is physically found on arrival.

Method	What	Detail
ASK	Cold-call directions test	Calls the listed number posing as a first-time patient asking for directions, and notes whether the answer is accurate without hesitation.

SUPERVISOR TIPS

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

EVIDENCE BASE

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

Pons PT, Markovchick VJ. Eight minutes or less: does the ambulance response time guideline impact trauma patient outcome? J Emerg Med. 2002;23(1):43-48.

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1.2 Hospital Grounds and Territory Entrance

NON-NEGOTIABLE

The hospital's territory begins at its first point of entry — the gate, main entrance, or boundary of the grounds — not at the building door. This entire approach is safe, clean, and clearly the hospital's own space from that first point.

In plain terms: The hospital's responsibility starts at its gate or boundary, not at the building door — the whole approach must be safe, clean, and clearly identifiable as the hospital.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A patient's first impression forms at the gate, not the reception desk. Broken lighting on the approach path, rubbish at the boundary, an unclear point where the street ends and the hospital begins — each of these tells a frightened patient that nobody is in charge. It also creates real hazards: unlit paths at night, uneven ground for wheelchairs, unclear boundaries where security cannot act. Facilities that maintain the building beautifully but neglect the grounds have a blind spot the patient sees first and remembers longest. The cost is trust lost before the first clinical contact.

WHAT GOOD LOOKS LIKE

- The grounds boundary is clearly identifiable, safe, and well maintained from the first point of entry.
- A single, unambiguous route leads from the entrance to the building.
- Lighting, walkways, and general upkeep of the grounds reflect the same standard expected inside the building.

COMMON FAILURE MODES

- The territory boundary is unclear, with no obvious sense of where hospital responsibility begins.
- Grounds are neglected, poorly lit, or unsafe to walk, even though the building itself is well kept.
- Multiple ambiguous paths from the entrance leave a first-time visitor uncertain which way to go.

WORKED EXAMPLE

IN PRACTICE

A district hospital on a large plot, with a main gate 150 metres from the building.

BEFORE

The gate had no hospital name on it — only a faded municipal sign. The path from gate to entrance had two broken lights and a section where paving had collapsed. Motorbike taxis parked across the pedestrian route. Patients arriving at night reported feeling unsafe. Management considered the grounds 'outside' and had no maintenance schedule for them.

ACTION

The Director walked the route at night with the Coordinator and facilities manager. They fixed the lights and paving within two weeks, painted the hospital name and logo on the gate, marked a pedestrian route with bollards, and added the grounds to the weekly maintenance checklist with a named person responsible.

AFTER

The Monitor walked from the street to the entrance at 8pm. The route was lit, clear, and unmistakably the hospital's from the gate onward. The maintenance log showed weekly checks. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk from the public street to your front door as a first-time visitor would — note everything.
2. Repeat the walk after dark.
3. Identify exactly where 'hospital territory' begins and whether that point is marked.
4. Add the grounds to the maintenance schedule with a named owner.

The most common mistake: Treating the car park and approach path as someone else's problem — the municipality's, a contractor's — so no one owns it.

SELF-ASSESSMENT QUESTIONS

1. Is the boundary of the hospital's grounds — gate, fence line, or first entry point — clearly identifiable as the hospital's own territory? — *Not the building itself — the point where a visitor first enters land the hospital is responsible for.*

Evidence: Photo of grounds boundary and entry point

2. Is the approach from that entry point to the building itself safe, maintained, and clean? — *Walkways, lighting, and general upkeep of the grounds themselves, not just the building interior.*

Evidence: Grounds maintenance record

3. Is there a single, clear route from the territory entrance to the main building, not multiple ambiguous paths? — *A confusing arrival*

sequence undermines confidence before the visit has even properly begun.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The building is well maintained, but the grounds have never received the same attention.** — Maintenance budgets and attention often stop at the building's own walls, leaving the approach overlooked.
- **The main route is fine but a secondary or older entrance is neglected.** — A less-used entrance can quietly fall out of the same maintenance cycle as the primary one.
- **Lighting is adequate during the day but poor at night, when it matters most for safety.**

IMPLEMENTATION PLAN

When	What
Week 1	Walk the full grounds approach, from territory boundary to building, and log every maintenance or safety gap found.
Week 2	Address the highest-priority safety gaps first — lighting, walkway condition, obstruction.
Week 3	Clarify signage or physical routing so the path from entrance to building is unambiguous.
Ongoing	Include grounds maintenance in the same routine inspection cycle as the building itself.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Grounds boundary check	Physically walks the entire approach from the territory's first entry point to the building, checking maintenance and safety.
OBSERVE	Route clarity test	Approaches as a first-time visitor would, checking whether the route from entry point to building is unambiguous.

Method	What	Detail
DOCUMENT	Grounds maintenance record review	Reviews maintenance and upkeep records for the grounds themselves, separate from building maintenance.

SUPERVISOR TIPS

- **Walk the actual approach yourself, don't assess the building alone.** — This standard is specifically about what happens before the building door, which is easy to overlook.
- **Check lighting and safety after dark if possible, not only during a daytime visit.** — Genuine safety gaps often concentrate in conditions the standard assessment visit doesn't naturally cover.

EVIDENCE BASE

Ulrich RS, Zimring C, Zhu X, et al. A Review of the Research Literature on Evidence-Based Healthcare Design. HERD. 2008;1(3):61-125.

WHO, Emergency Care System Framework (2 May 2018).

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1.3 Physical Access, or a Real Plan

NON-NEGOTIABLE

At least one entrance is usable by a wheelchair user without staff needing to lift or carry them. Where full access does not yet exist, the facility holds a specific, budgeted, dated plan to close the gap.

In plain terms: A wheelchair user can enter through at least one door without being carried — or, if not yet, you have a real plan with money and a date to fix it.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Being carried into a hospital is undignified and dangerous — for the patient and for the staff lifting them. Many older buildings were built without ramps, and fixing that costs money the facility may not yet have. ASF does not pretend otherwise. But there is a sharp line between 'we have no ramp and a dated, budgeted plan to build one' and 'we have no ramp and no plan.' The first is a facility on a path; the second is a facility that has decided some patients matter less. The legal exposure is real too: disability access is a legal requirement in most countries, and a documented plan is the difference between good faith and negligence.

WHAT GOOD LOOKS LIKE

- A clear, unobstructed accessible route verified on the day of assessment.
- A funded, dated plan with a contractor already selected and visible first steps taken.
- Front-line staff describe genuine, dignified assistance procedures without hesitation.

COMMON FAILURE MODES

- "We've been meaning to build a ramp" — no document, no budget, no date, unchanged from the year before.
- A ramp exists on paper but is blocked by stored equipment on the day of the visit.
- Staff describe assistance as improvised, with no actual procedure or training behind it.

WORKED EXAMPLE

IN PRACTICE

A 60-bed hospital in a 1970s building with three steps at every entrance.

BEFORE

Wheelchair patients were lifted up the front steps by porters. Two porters had back injuries in the previous year. The Director knew a ramp was needed but there was no budget line, no drawing, no date — just an intention. When asked, staff said 'we manage.'

ACTION

The Coordinator got a quote for a compliant ramp at the side entrance (the cheapest option). The Director put it in the next budget with a named

completion date eleven months out. Meanwhile they bought a portable ramp for the side door as an interim measure and wrote a one-page plan: what, where, cost, date, who is responsible.

AFTER

The Monitor reviewed the signed plan with the budget line, the quote, and the date. They observed the portable ramp in use. The criterion is met on the basis of a genuine plan — not yet on full access — and will be re-checked at the date.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Try to enter every public door in a wheelchair, or with someone who uses one.
2. If none works: get one written quote for the cheapest compliant fix.
3. Put that quote in front of the Director with a proposed completion date.
4. Write the plan on one page: what, where, cost, date, owner — and have the Director sign it.

The most common mistake: Saying 'we plan to build a ramp' without a budget line, a date, or a document — an intention is not a plan.

SELF-ASSESSMENT QUESTIONS

1. Is there at least one entrance a wheelchair user can use without staff physically lifting or carrying them? — *A step, a narrow doorway, or a heavy unassisted door all count as a barrier.*

Evidence: Photo of entrance route

2. If not, is there a specific, budgeted, dated plan to close the gap? — *Not "we've discussed it" — a named structural change, a budget line, a date.*

Evidence: Capital plan or board minutes

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

Evidence: Quote, order, or contract

COMMON REASONS FOR A PARTIAL ANSWER

- **A ramp exists but was never checked for actual usability.** — Grade too steep, surface uneven, or door at the top too heavy — built once, never tested by an actual wheelchair user.
- **A plan exists in someone's head but was never written down or costed.** — Good intentions with no budget line are indistinguishable from no plan once someone asks for the document.
- **Access exists at one entrance but staff don't know to direct people there.**

IMPLEMENTATION PLAN

When	What
Week 1	Physically test your own accessible route and document every barrier found.
Week 2	Get a real quote for the smallest fix that closes the largest gap.
Week 3	Put a specific budget line and date in front of whoever approves facility spending, in writing.
Month 2	Train front-line staff on a real, dignified assistance procedure for the gap between now and the fix.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Physical route check	Walks the accessible route from the street or car park to the entrance, checking for steps, doorway width, and obstructions.
DOCUMENT	Plan verification	If access is incomplete, requests the accessibility plan directly.
ASK	Front-line staff interview	Asks a front-line staff member how they would actually assist a wheelchair user arriving right now.

SUPERVISOR TIPS

- **Walk the route yourself, don't take a photo's word for it.** — Grade and surface texture matter in ways photos hide.
- **Ask for the plan document before commenting on what you observed.** — A facility that produces a real document quickly usually has a real plan.

EVIDENCE BASE

United Nations. Convention on the Rights of Persons with Disabilities, Article 9 — Accessibility. New York: UN; 2006.

United Nations. Convention on the Rights of Persons with Disabilities, Article 4(2) — Progressive Realisation. New York: UN; 2006.

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1.4 Emergency Entrance, Marked and Clear

NON-NEGOTIABLE

Where the facility has a distinct emergency entrance, it is clearly marked from the approach a person would actually take, visible before arrival, and kept clear at all times.

In plain terms: If you have a separate emergency entrance, a stranger arriving by car or on foot can see the sign for it before they reach the wrong door — and the route is never blocked.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

When someone is having a heart attack in the back seat, the driver does not have time to read three signs and reverse. If your emergency entrance is only marked once you are already in the car park, you have wasted the seconds that matter most. The second failure is subtler: the route is signed but a delivery truck parks across it every morning, or bins are left in the ambulance bay. A route that is clear when you check it and blocked at 7am on Tuesdays is not clear. Emergency access failures rarely appear in incident reports because nobody records the two minutes lost — but they are lost.

WHAT GOOD LOOKS LIKE

- A sign is visible from the main road, before the turn

COMMON FAILURE MODES

- Signage only becomes visible once already in the

into the grounds, with the route kept clear.

- Staff give the same, immediate, confident directions when asked separately.

car park.

- Two staff members give two different answers when asked directly.

WORKED EXAMPLE

IN PRACTICE

A 200-bed hospital with a dedicated emergency entrance on a side street.

BEFORE

The only 'EMERGENCY' sign was above the emergency door itself — invisible from the main road. Drivers routinely arrived at the main entrance and were redirected, losing three to five minutes. The Coordinator asked three staff for directions; each described a different route. Deliveries parked in the ambulance bay between 6 and 8am.

ACTION

The Coordinator drove the approach from both directions and timed when the sign became visible: never, from the main road. They installed a large sign at the main road turn and another at the car park entrance. Facilities painted the ambulance bay red with 'NO PARKING — AMBULANCE' and briefed the delivery contractor. All front-line and security staff were given one printed direction script.

AFTER

The Monitor drove the approach and saw the emergency sign 200 metres before the turn. They visited at 7am and found the bay clear. Two staff, asked separately, gave identical directions. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Drive or walk toward your hospital from the main road — when do you first see 'EMERGENCY'?

2. Ask three staff members separately how to direct someone to the emergency entrance.
3. Check the route at your busiest delivery time, not at a quiet moment.
4. Fix the single biggest visibility gap first — usually a sign at the road.

The most common mistake: Confirming the emergency sign exists instead of testing when it becomes visible to an approaching driver.

SELF-ASSESSMENT QUESTIONS

1. Is the emergency entrance signed clearly enough to be seen before arriving at the main door? — *Visible from the approach a real ambulance or member of the public would take.*

Evidence: Photo from approach point

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

Evidence: Routine clearance log, if kept

3. Would two different staff members give the same directions to it if asked separately? — *Inconsistent directions from staff usually means the signage itself is inadequate.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Signage was designed for vehicles, not pedestrians, or the reverse.** — A facility serving both often only signs for one.
- **The route is clear during the day and blocked by deliveries at other times.** — Assessed once, on a quiet day, the gap between routine and exception can go unnoticed.
- **Signage exists but wasn't updated when the entrance itself moved.**

IMPLEMENTATION PLAN

When	What
Week 1	Walk and drive the actual approach routes, timing when signage becomes visible.
Week 2	Fix the single biggest visibility gap first.

When	What
Week 3	Brief all front-line and security staff on a single, consistent set of directions.
Ongoing	Recheck route clearance at different times of day.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Approach visibility test	Approaches from the direction the public or an ambulance would arrive, checking when signage first becomes visible.
OBSERVE	Route clearance check	Checks whether the route beneath the signage is physically clear.
ASK	Staff consistency test	Separately asks two different staff members for directions, without either knowing the other was asked.

SUPERVISOR TIPS

- **Time the approach, don't just confirm the sign exists.** — A sign visible only for the last five metres fails the same way as no sign.
- **Ask directions from someone who isn't reception.** — Reveals whether the knowledge is actually distributed.

EVIDENCE BASE

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

United Nations. Convention on the Rights of Persons with Disabilities, Article 9(1)(b). New York: UN; 2006.

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1.5 Wayfinding Without Staff Dependence

CORE

Basic wayfinding allows someone with no prior knowledge of the building to locate reception, toilets, and the main

clinical areas without stopping to ask for directions more than once.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

- Reception, toilets, and at least one clinical area are locatable by signage alone.
- A visitor already in the building confirms wayfinding felt straightforward.

COMMON FAILURE MODES

- A single sign board at the main door and nothing beyond it.
- Ground-floor signage is clear; upper floors have none at all.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital across three connected buildings with a mix of old and new signage.

BEFORE

The Coordinator asked a friend who had never visited to find the outpatient X-ray department

from the front door. She asked for directions four times. Signs used department names that had changed. One corridor had a sign pointing left to 'Radiology' and another pointing right to 'X-Ray' — the same place. Toilet signs were absent from two of three waiting areas.

ACTION

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

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Can a first-time visitor find reception using only your posted signage? — *Not staff intercepting and redirecting.*

Evidence: N/A — tested directly

2. Can they find the nearest toilet and one named clinical department the same way? — *Test this with someone who has*

genuinely never been inside the building before.

Evidence: N/A — tested directly

3. Is signage consistent across every floor, or does it stop after the ground floor? — *A common, specific failure.*

Evidence: Photos, floor by floor

COMMON REASONS FOR A PARTIAL ANSWER

- **Signage exists but uses internal department codes, not patient-facing names.** — Staff know what "Ward 4B" means; a first-time visitor does not.
- **Ground floor is signed because it was renovated recently; upper floors were never touched.** — Wayfinding quality often tracks renovation history rather than a deliberate standard.
- **Signage exists in one language only, in a facility serving a multilingual population.**

IMPLEMENTATION PLAN

When	What
Week 1	Have someone with no prior knowledge navigate the building, and log every point of confusion.
Week 2	Fix the highest-traffic gap first.
Month 2	Extend consistent signage to every floor, using patient-facing names.
Ongoing	Re-test with a genuine first-time visitor whenever the layout changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	First-time visitor test	Enters as a first-time visitor and attempts to locate reception, toilet, and one department using only signage.
OBSERVE	Staff-query count	Notes exactly how many times a staff member had to be asked for directions.
ASK	Independent visitor check	Asks a visitor already in the building whether they found their way easily.

SUPERVISOR TIPS

- **Use a genuinely unfamiliar tester.** — Anyone with prior exposure fills gaps a true first-time visitor cannot.
- **Count staff queries precisely, don't estimate.** — "A couple of times" and "zero times" are very different outcomes.

EVIDENCE BASE

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

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

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← **Hospital Standards — all standards**

Self-assess against these criteria →

Standard 2 — Reception & Information →

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ASF STANDARDS · HOSPITAL · STANDARD 2

Standard 2 — Reception & Information

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

CRITERIA IN THIS STANDARD

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

2.1 Patients Know Their Rights

NON-NEGOTIABLE

A patient rights charter exists, is visibly displayed, and patients can describe it in their own words — not a document filed away that nobody references. The charter explicitly names privacy, dignity and respect, confidentiality, personal safety and security, how consent is granted, the right to refuse treatment, and recognition of the patient's cultural and spiritual preferences, including access to spiritual or religious care on request.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

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

COMMON FAILURE MODES

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

WORKED EXAMPLE

IN PRACTICE

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

BEFORE

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

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Is a patient rights charter visibly displayed in areas patients actually pass through? — *Not filed in an office — posted somewhere a patient waiting or arriving would see it.*

Evidence: Photo of displayed charter

2. Is the charter written in plain language, in the languages patients actually speak? — *A legal document patients can't parse doesn't meet this, regardless of how thorough it is.*

Evidence: Charter text, all language versions

3. Can a patient asked directly describe at least one of their rights in their own words? — *Not whether the charter exists — whether it*

reached them.

Evidence: N/A — tested directly

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

Evidence: Charter text, staff interview

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

Evidence: Chaplaincy or spiritual-care request process

COMMON REASONS FOR A PARTIAL ANSWER

- **The charter is displayed but only in the language of the majority population.** — A meaningful minority of patients may be functionally unable to read the one version posted.
- **The charter is posted but written in legal or clinical language patients don't parse easily.** — Technically available and practically accessible are different things.
- **Staff know the charter exists but have never actively explained it to a patient.**

IMPLEMENTATION PLAN

When	What
Week 1	Check current charter display locations and language coverage against actual patient-facing areas.
Week 2	Rewrite the charter in plain language if the current version is legal or clinical in tone.
Week 3	Translate into the languages your patient population actually speaks.
Ongoing	Brief reception and ward staff to actively reference the charter, not just display it passively.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Display check	Checks whether the rights charter is genuinely visible in patient-facing areas, not just technically present somewhere in the building.
ASK	Patient awareness test	Asks a patient, unprompted, whether they know they have specific rights as a patient here, and what those are.
DOCUMENT	Language coverage check	Reviews which languages the charter is available in against the languages the patient population actually speaks.

SUPERVISOR TIPS

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

EVIDENCE BASE

[33] WHO's framework for people-centred health services identifies patient awareness of their own rights as a precondition for meaningful participation in their own care, not a downstream courtesy.

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2.2 Pricing Is Disclosed Before Care Begins

CORE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

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

COMMON FAILURE MODES

- Patients learn the cost only when the final bill arrives.
- Pricing is mentioned verbally once, with no written record for the patient to keep.
- Patients report being surprised by charges never mentioned beforehand.

WORKED EXAMPLE

IN PRACTICE

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

BEFORE

Prices existed in a spreadsheet at the cashier's desk. Patients were told costs verbally, sometimes, by whoever admitted them. The Coordinator reviewed the last 20 complaints: 8

were about unexpected charges. Patients said they were told one figure and billed another because of items not mentioned — dressings, lab tests, a second night.

ACTION

The Coordinator built a one-page estimate template listing the procedure, expected stay, common extras, and a total range. Admission staff were required to complete it, explain it, and give the patient a copy before any elective admission. For emergencies, the estimate was given as soon as the patient was stable. A signature line confirmed the patient had received it.

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Is pricing information provided to patients before treatment begins, not only on the final invoice? — *Cost disclosure after the fact doesn't allow informed decision-making.*

Evidence: Pricing disclosure sample

2. Is pricing information given in a form the patient can keep and review, not only spoken once? — *A verbal mention easily forgotten under stress is not the same as a document the patient can refer back to.*
Evidence: Written estimate or pricing sheet

3. Can a patient describe roughly what they were told a procedure would cost, after being told? — *Tests whether the disclosure actually registered, not just whether it technically happened.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Pricing is disclosed for major procedures but not consistently for smaller add-on services.** — Ancillary charges often accumulate without the same disclosure discipline applied to the primary procedure.
- **A written estimate is given but in language or format patients find hard to actually use.** — Technical or dense pricing sheets can technically satisfy the requirement while functionally failing patients.
- **Disclosure happens reliably for planned admissions but less consistently for urgent or emergency care.**

IMPLEMENTATION PLAN

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

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Disclosure timing review	Reviews a sample of patient records or billing files for evidence pricing was disclosed before treatment, not only invoiced after.

Method	What	Detail
OBSERVE	Written disclosure format check	Checks whether pricing information is provided in a retainable written form, not only spoken.
ASK	Patient recall check	Asks a recently treated patient what they recall being told about cost before their procedure.

SUPERVISOR TIPS

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

EVIDENCE BASE

[38] WHO's guidance on universal health coverage identifies financial transparency at the point of care as a core determinant of patients' ability to exercise informed choice, particularly in out-of-pocket payment settings.

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2.3 Reception Desk Accessibility

NON-NEGOTIABLE

At least one reception or registration point is at a height a wheelchair user can approach and communicate with the receptionist at eye level — not looking up at a standard-height counter designed only for someone standing.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

- At least one clearly usable, wheelchair-height reception point exists and is kept clear.
- A wheelchair user can interact with the receptionist at genuine eye level.
- Reception staff are aware of and actively use the accessible point without needing to be reminded.

COMMON FAILURE MODES

- The entire reception desk is standard height, with no accessible alternative.
- A lower section exists but is permanently covered with files, boxes, or equipment.
- Staff are unaware an accessible point exists or don't know to direct patients there.

WORKED EXAMPLE

IN PRACTICE

A 100-bed hospital whose main reception is a single 1.1-metre counter.

BEFORE

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

ACTION

Facilities cut a 90-cm section at one end of the counter and lowered it to 75 cm with knee clearance underneath, at a cost of one day's

carpentry. A small sign marked it. Reception staff were told to invite wheelchair users to that end.

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

- 1.** Is at least one reception or registration point at a height a wheelchair user can comfortably use? — *Not the whole desk — at least one section genuinely usable at wheelchair height.*

Evidence: Photo of reception desk height

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

Evidence: N/A — tested directly

- 3.** Is the lower section actually kept clear and usable, not blocked by files, equipment, or signage? — *A lower desk section that exists but is permanently cluttered doesn't meet this in practice.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A lower section was built but has gradually become a storage spot for overflow items.** — Good intentions at design stage don't guarantee the space stays usable in daily practice.

- **The accessible point exists but is positioned awkwardly, away from the main queue.** — Physical accessibility without practical, dignified positioning only partly closes the gap.
- **New staff aren't briefed on the accessible point during their own induction.**

IMPLEMENTATION PLAN

When	What
Week 1	Check current reception desk height against accessible design guidelines.
Week 2	If no accessible section exists, identify the lowest-cost way to add one — a lowered counter segment is often sufficient.
Week 3	Clear and designate the accessible section, briefing all reception staff on its purpose.
Ongoing	Include the accessible reception point in routine facility walk-throughs to ensure it stays clear.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Desk height check	Physically checks reception desk height against standard wheelchair-accessible height guidelines.
OBSERVE	Clear access test	Checks whether the lower section, if present, is genuinely clear and usable, not obstructed by clutter.
ASK	Staff awareness interview	Asks reception staff whether they're aware of and actively use the accessible section when needed.

SUPERVISOR TIPS

- **Physically check the height yourself, don't just ask if one exists.** — A technically accessible section that's cluttered or awkwardly placed doesn't function as intended.
- **Ask a reception staff member to demonstrate, not just describe.** — Genuine practical use versus theoretical awareness shows in how confidently they can point to it.

EVIDENCE BASE

[26] UN CRPD, Article 9 — Accessibility (2006), which explicitly requires accessible design of service points, not only structural access to a

building.

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2.4 **Health Information Is Genuinely Understandable, Not Just Provided**

CORE

Health information given to patients — about their condition, options, and next steps — is delivered in plain language and verified as actually understood, not handed over in clinical terminology and assumed to have registered.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

- Information is consistently delivered in genuine plain language.
- Patient understanding is actively verified, not assumed.

COMMON FAILURE MODES

- Information relies on unexplained clinical terminology.
- Understanding is assumed from a nod, with no active verification.

- Materials are available in the languages the patient population actually needs.

- Materials exist only in the facility's default language regardless of patient population need.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital where doctors explain diagnoses at the bedside during rounds.

BEFORE

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

ACTION

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

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

4. Add a teach-back tick box to discharge documentation.

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

SELF-ASSESSMENT QUESTIONS

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

Evidence: Patient information materials sample

2. Is patient understanding actively verified, such as through teach-back, not assumed from a nod? — *An active check, not passive delivery followed by an assumption it landed.*

Evidence: N/A — tested directly

3. Are information materials available in the languages the patient population actually needs, not just the primary local language? — *Matched to actual population need, not a single default assumption.*

Evidence: Language coverage of information materials

COMMON REASONS FOR A PARTIAL ANSWER

- **Plain language is used for major decisions but reverts to clinical shorthand for routine information.** — Simplification effort often concentrates on high-stakes moments, leaving routine communication less accessible.
- **Verification happens for complex decisions but not for everyday instructions.** — Misunderstood routine instructions still carry real risk, even if lower stakes than major decisions.
- **Materials exist in the majority language but not the languages of smaller patient populations actually served.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current patient information materials and typical conversation practice for plain-language use.
Week 2	Train staff on teach-back or equivalent understanding-verification techniques.

When	What
Week 3	Assess language coverage against the actual patient population and address gaps.
Ongoing	Spot-check patient understanding periodically across both major and routine information.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Plain language practice check	Reviews patient information materials and observes clinical conversations for genuine plain-language use.
OBSERVE	Understanding verification observation	Observes whether patient understanding is actively checked, not assumed, during information delivery.
DOCUMENT	Language coverage review	Reviews information materials against the languages the actual patient population needs.

SUPERVISOR TIPS

- **Ask a patient to explain back what they were told, not whether they understood.** — This tests actual comprehension rather than self-reported confidence.
- **Check materials for a less common language in the patient population, not just the majority one.** — Coverage gaps concentrate exactly where they're least visible in a general review.

EVIDENCE BASE

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

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2.5 Waiting and Queue Time Is Actively Managed

CORE

Patients waiting for registration, triage, or an ambulatory appointment are managed through a defined queue system with visible, honest wait-time information — not left to wonder, unmanaged, how long they'll wait or whether they've been forgotten.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

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

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

WHAT GOOD LOOKS LIKE

- A defined queue management system operates consistently, even during busy periods.
- Honest, reasonably accurate wait-time information is genuinely visible or communicated.
- Staff describe an active process for monitoring waiting patients, not just managing queue order.

COMMON FAILURE MODES

- No defined system exists beyond an informal sense of who arrived first.
- No wait-time information is available, or given information is routinely inaccurate.
- No mechanism exists to notice a waiting patient's condition changing before they're called.

WORKED EXAMPLE

IN PRACTICE

A 120-bed hospital whose outpatient department sees 300 patients a day with no queue system.

BEFORE	Patients crowded the corridor outside each consulting room. Order was by whoever pushed forward. Staff did not know how many were waiting. Complaints about queue-jumping were weekly. One patient collapsed in the corridor after waiting three hours unseen. No one could say how long the wait was on any given morning.
ACTION	The Coordinator introduced numbered tickets at registration and a whiteboard per clinic showing the number now being seen. A nurse was assigned to walk each waiting area every 30 minutes to check on anyone looking unwell. Staff were told to give an honest time estimate when asked, based on the whiteboard.
AFTER	The Monitor observed the outpatient area at 9am: tickets in use, board updated, nurse walking the room. Three patients said they had been told a wait time and it was roughly right. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Is there a defined queue management system for registration, triage, and ambulatory waiting, not an informal first-come approach with no structure? — *A specific, functioning system, not assumed to be self-evident from a waiting room and a door.*

Evidence: Queue management system description

2. Is honest wait-time information visible or communicated to waiting patients? — *Genuine, reasonably accurate information, not a vague reassurance or no information at all.*

Evidence: Wait-time communication method

3. Is there a mechanism to notice if a waiting patient's condition changes or worsens while they wait? — *Active monitoring of the waiting area, not only the queue order itself.*

Evidence: Waiting area monitoring process

COMMON REASONS FOR A PARTIAL ANSWER

- **A queue system works well during normal hours but breaks down during unusually busy periods.** — The system is most needed exactly when it's under the most strain, and that's often when it's least tested.
- **Wait-time information is displayed but isn't updated as actual conditions change, becoming inaccurate.** — Stale information can be worse than no information, since it actively misleads rather than simply being absent.
- **Monitoring exists for the triage waiting area specifically but not for ambulatory clinic waiting rooms.**

IMPLEMENTATION PLAN

When	What
Week 1	Observe current queue management practice, particularly during a known busy period.
Week 2	Establish or reinforce a defined queue system with visible wait-time communication.
Week 3	Build a periodic waiting-area check into staff routine to catch condition changes while patients wait.
Ongoing	Review wait-time accuracy and queue system performance periodically, especially during peak periods.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **Observe during a genuinely busy period, not a quiet one.** — Queue management systems that work fine when quiet often reveal their real gaps under pressure.
- **Ask how long it's actually been since the waiting area was last checked for anyone whose condition may have changed.** — A specific, real answer reveals whether this is genuine practice or a theoretical process.

EVIDENCE BASE

Structured queue management and wait-time transparency are established elements of patient experience and flow-safety frameworks in ambulatory and emergency healthcare settings internationally, linked to both patient satisfaction and earlier identification of clinical deterioration during waiting periods.

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← **Hospital Standards — all standards**

Self-assess against these criteria →

← **Standard 1 — Access & Arrival**



Standard 3 — Environment & Shared Spaces →

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ASF STANDARDS · HOSPITAL · STANDARD 3

Standard 3 — Environment & Shared Spaces

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

CRITERIA IN THIS STANDARD

3.1 — Water Supply Is Safe and Monitored

3.2 — Medical Equipment Is Maintained on Schedule

3.3 — Shared Spaces Are Genuinely Clean

3.4 — Facility Risks Are Tracked in One Integrated Register

3.5 — An Environmental Sustainability Programme Is Genuinely Active

3.6 — Facility Signage Is Complete, Not Just Present at Reception

3.1 Water Supply Is Safe and Monitored

NON-NEGOTIABLE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

- Water testing happens on a defined schedule with consistent, retained records.
- A specific, actionable contingency plan exists for supply interruption.
- Concerning results trigger a known, followed response process.

COMMON FAILURE MODES

- No regular testing schedule exists beyond an assumption of municipal safety.
- No contingency plan exists for interruption.
- Test results, when they exist, are filed without review or follow-up.

WORKED EXAMPLE

IN PRACTICE

A 180-bed hospital on municipal supply with a rooftop storage tank.

BEFORE

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

ACTION

The Coordinator arranged quarterly microbiological testing at a certified laboratory and had the tank drained, cleaned, and inspected. A written contingency plan named who calls whom, where the 48-hour bottled reserve is stored, which services stop first, and how hand hygiene continues (alcohol rub stock). Results and the plan were filed in the risk register.

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Is water quality tested on a defined, regular schedule, with records kept? — *"It's municipal water, it's fine" is an assumption, not a verified fact.*

Evidence: Water testing records

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

Evidence: Contingency plan document

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

COMMON REASONS FOR A PARTIAL ANSWER

- **Testing happens but the schedule has gaps, particularly during busy periods.** — A routine task without a strong enforcement mechanism is often the first thing skipped when short-staffed.
- **A contingency plan exists but has never been tested or reviewed since it was written.** — An untested plan may not reflect current facility capacity or actual supplier arrangements.
- **Results are reviewed by one person informally, with no documented follow-up process.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current water testing frequency and records for gaps.
Week 2	Establish or reinforce a specific, written contingency plan for supply interruption.
Week 3	Define a clear, named response process for concerning test results.
Ongoing	Review testing consistency and contingency plan currency on a fixed schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Testing record review	Reviews water testing records for consistency, frequency, and whether the schedule is actually followed.
DOCUMENT	Contingency plan check	Reviews the contingency plan for water interruption for specificity — is there a real backup supply arrangement, not just a statement of concern.
ASK	Response protocol interview	Asks facility management staff to describe what actually happens if a test result comes back concerning.

SUPERVISOR TIPS

- **Ask for actual test records, not a statement that testing happens.** — Dated records are the only real evidence of a consistent schedule.
- **Ask what happened the last time a result was concerning, if ever.** — A real example, or the honest absence of one, reveals more than a description of policy.

EVIDENCE BASE

[31] WHO's guidelines on water, sanitation, and hygiene in health care facilities identify regular water quality testing as foundational to infection prevention, not a peripheral utilities concern.

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3.2 Medical Equipment Is Maintained on Schedule

NON-NEGOTIABLE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A ventilator that has not been serviced fails at 3am. An infusion pump that drifts delivers the wrong dose. A defibrillator with a flat battery is a box. Equipment failure is a leading cause of preventable patient harm and is almost entirely predictable — machines fail on schedules, which

is why manufacturers publish service intervals. The harder discipline is removing faulty equipment from use. It is tempting to keep a monitor with an intermittent fault in service because there is no spare. That is how a known fault becomes a death. Tag it, remove it, find a workaround. Equipment that is 'mostly working' is not working.

WHAT GOOD LOOKS LIKE

- A comprehensive maintenance schedule covers all clinical equipment, consistently followed.
- Faulty equipment is physically removed from use immediately, not left accessible.
- A named person owns the programme and can describe it confidently.

COMMON FAILURE MODES

- Maintenance happens reactively, only after equipment visibly fails.
- Equipment flagged as faulty remains physically available and is sometimes used anyway.
- Nobody can identify who is responsible for the maintenance programme.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital with 400 items of clinical equipment and one biomedical technician.

BEFORE

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

ACTION

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

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Is there a documented maintenance schedule covering all clinical equipment? — *Not equipment maintained "as needed" or reactively — a defined, proactive schedule.*

Evidence: Maintenance schedule and log

2. Is faulty equipment actually removed from use, not kept in service while awaiting repair? — *A tag or note isn't sufficient if the equipment*

remains physically accessible for use.

Evidence: Removal-from-service record

3. Is there a named person or role responsible for the maintenance programme? — *Responsibility spread across nobody in particular usually means it happens inconsistently.*

Evidence: Role assignment record

COMMON REASONS FOR A PARTIAL ANSWER

- **A schedule exists for major equipment but not consistently for smaller or older items.** — Coverage often reflects equipment value or visibility rather than actual risk.
- **Faulty equipment is tagged but not physically relocated away from use.** — A tag depends on every staff member noticing and respecting it every time — physical removal doesn't.
- **Maintenance responsibility sits with someone who has since changed roles, informally.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit current equipment against the maintenance schedule for coverage gaps.
Week 2	Establish a clear, enforced process for physically removing faulty equipment from use.
Week 3	Name a specific person or role as owner of the maintenance programme.
Ongoing	Review maintenance log currency against the defined schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Maintenance schedule review	Reviews the maintenance schedule and log for completeness across all clinical equipment, and for consistency with actual dates.
OBSERVE	Faulty equipment check	Checks whether any equipment currently flagged as faulty is still physically accessible for use.

Method	What	Detail
ASK	Responsible person interview	Asks whoever is responsible for the maintenance programme to describe the actual process, not just the policy.

SUPERVISOR TIPS

- **Look for equipment that should be flagged but isn't, not just check the flagged items.** — The absence of any flagged equipment across an entire facility is itself worth questioning.
- **Check whether tagged-faulty equipment is still physically reachable.** — A tag alone doesn't prevent use if the equipment sits in its normal location.

EVIDENCE BASE

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

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3.3 Shared Spaces Are Genuinely Clean

CORE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

- A documented, consistently followed cleaning schedule covers all shared spaces.
- High-touch surfaces are specifically and routinely addressed.
- Cleanliness is verified through a defined process, not visual impression alone.

COMMON FAILURE MODES

- No documented schedule exists beyond general good intentions.
- High-touch surfaces show visible neglect relative to more prominent areas.
- Verification, if it exists, is undocumented and inconsistent.

WORKED EXAMPLE

IN PRACTICE

A 100-bed hospital with an outsourced cleaning contractor.

BEFORE

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

ACTION

The Coordinator obtained the contractor's schedule, revised it with infection control to specify high-touch surfaces and frequency, and required a signed daily log per area. The ward sister spot-checked one area per day with a 10-

point checklist. Monthly ATP swabs of five high-touch points were added, with results recorded.

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

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

Evidence: Cleaning schedule and log

2. Is cleaning verified through more than a visual check, such as a defined inspection process? — *Visual cleanliness and actual microbial cleanliness aren't the same thing.*

Evidence: Verification or audit record

3. Are high-touch surfaces specifically included in the schedule, not just visible floor and surface areas? — *Door handles, rails, and switches are easy to overlook relative to more visible surfaces.*

Evidence: High-touch surface schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **A schedule exists for main patient areas but not consistently for peripheral shared spaces.** — Corridors, waiting rooms, and less-visited areas often receive less consistent attention.

- **Cleaning happens but high-touch surfaces aren't specifically called out in the schedule.** — A general cleaning routine can miss the specific surfaces that matter most for transmission risk.
- **Verification exists informally but isn't documented or consistently applied.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current cleaning schedules for coverage gaps, particularly high-touch surfaces.
Week 2	Add or reinforce specific high-touch surface cleaning to the documented schedule.
Week 3	Establish a simple, documented verification step beyond visual inspection.
Ongoing	Audit cleaning log completeness and verification records periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Cleaning schedule and log review	Reviews the documented cleaning schedule against actual completion records for shared spaces.
OBSERVE	High-touch surface check	Checks specifically whether high-touch surfaces are included in and reflected by the cleaning routine.
ASK	Verification process interview	Asks cleaning or infection control staff to describe how cleanliness is actually verified, beyond visual inspection.

SUPERVISOR TIPS

- **Check high-touch surfaces specifically, not general visible cleanliness.** — Door handles, light switches, and rails reveal more about routine practice than open floor areas.
- **Ask for the log, not a general assurance that cleaning happens.** — Dated records are the only real evidence of a consistent schedule.

EVIDENCE BASE

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

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3.4 Facility Risks Are Tracked in One Integrated Register

NON-NEGOTIABLE

Water safety, fire safety, equipment maintenance, and other facility risks are tracked together in one reviewed risk register — not as separate, disconnected checklists that nobody views as a whole picture.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Facility risks across all domains feed into one integrated, actively maintained register.
- The register is reviewed on a defined schedule by facility leadership.
- Risks are prioritised, with the highest-risk items visibly addressed first.

- Water safety, fire safety, and maintenance records exist as entirely separate, unconnected logs.
- No defined review schedule exists at a leadership level.
- All items are treated with equal, undifferentiated priority, or not prioritised at all.

WORKED EXAMPLE

IN PRACTICE

A 160-bed hospital with fire, water, equipment, and building risks tracked by four different people.

BEFORE

Each department kept its own list. The Director had never seen them together. When the Coordinator collected them, she found the backup generator was overdue for service, the fuel store had a fire-rating issue, and the fire officer had flagged the generator room as a risk — three findings, three files, no connection, no action.

ACTION

The Coordinator built one register: risk, likelihood, impact, owner, current controls, next action, review date. She populated it from the four existing lists, scored each, and sorted by priority. The top ten went to the management meeting monthly. The generator issue was resolved in three weeks once all three findings were seen together.

AFTER

The Monitor reviewed the register: 34 risks, each with an owner and a dated review. Minutes of two management meetings showed the top ten discussed and actions closed. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Do water safety, fire safety, and equipment maintenance data feed into one integrated risk register, not separate untracked lists? — *A single place where facility leadership can see the whole risk picture, not scattered logs nobody reviews together.*
Evidence: Integrated risk register document

2. Is the register reviewed on a defined schedule by facility leadership, not just maintained by individual department staff? — *Review at a level that can act across domains, not only within one narrow area.*
Evidence: Review meeting record

3. Does the register prioritise risks, not just list them? — *A genuine risk management tool ranks what needs attention first, rather than treating every item as equally urgent.*
Evidence: Risk prioritisation criteria

COMMON REASONS FOR A PARTIAL ANSWER

- **Individual domain tracking is strong, but nothing yet integrates them into one register.** — Good individual records don't automatically produce a combined view without deliberate effort to build one.
- **A register exists but review happens irregularly rather than on a fixed schedule.** — An ad hoc review pattern risks the register becoming stale between infrequent looks.
- **The register lists risks but doesn't clearly rank which need attention first.**

IMPLEMENTATION PLAN

When	What
Week 1	Inventory current facility safety tracking across water, fire, equipment, and other domains.
Week 2	Consolidate these into one integrated risk register.
Week 3	Establish a defined review schedule at an appropriate leadership level.
Ongoing	Review and reprioritise the register on the defined schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Register completeness review	Reviews the risk register for integration across water, fire, equipment, and other facility safety domains.
DOCUMENT	Review schedule check	Checks for evidence the register is reviewed on a defined schedule at an appropriate leadership level.
ASK	Prioritisation interview	Asks whoever owns the register to describe how risks are prioritised, not just logged.

SUPERVISOR TIPS

- **Ask to see the register itself, not descriptions of individual domain tracking.** — The integration itself is what this standard checks, not whether individual pieces exist.
- **Ask who reviews it and how often, specifically.** — A specific, named review process is the real evidence of active use, not passive existence.

EVIDENCE BASE

Integrated environment-of-care risk management, tying individual facility safety domains into one reviewed register, is an established approach in international facility safety frameworks specifically because siloed tracking misses compounding and cross-cutting risks.

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3.5 An Environmental Sustainability Programme Is Genuinely Active

CORE

The facility has a specific, documented environmental sustainability programme — covering energy use, waste reduction, and resource consumption — with real, tracked progress, not a general statement of environmental awareness with no measurable action behind it.

In plain terms: The hospital has a real, written environmental programme — energy, waste, water, resources — with targets it actually tracks, not just a green statement.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Adapted	Adapted	Full

WHY THIS MATTERS

Hospitals are among the most resource-intensive buildings in any city: running 24 hours, generating clinical waste, consuming energy for sterilisation, heating, cooling, and imaging. Waste that is not managed pollutes the community the hospital serves. Energy that is wasted is money not spent on care. Beyond ethics, there is a direct financial case: facilities with a tracked programme typically cut utility costs by 10–20% in the first two years. The standard does not demand a sophisticated programme; it demands a real one — specific actions, baseline numbers, and evidence of tracking. A sustainability poster is not a programme.

WHAT GOOD LOOKS LIKE

- A specific, written programme covers energy, waste, and resource use with real detail.
- Progress is tracked against measurable targets, with genuine data.
- A named person or team owns the programme and

COMMON FAILURE MODES

- No specific programme exists beyond a general environmental values statement.
- No tracking exists to demonstrate any measurable progress.
- Nobody is specifically responsible for the programme.

can describe real, current initiatives.

WORKED EXAMPLE

IN PRACTICE

A 130-bed hospital with rising utility bills and no environmental policy.

BEFORE

There was a sentence about environmental responsibility in the mission statement and nothing else. Nobody knew the monthly electricity consumption. Clinical and general waste were often mixed. Lights ran all night in unused areas.

ACTION

The Coordinator and facilities manager took three baseline measurements: monthly kWh, monthly water, kg of clinical waste. They wrote a one-page programme with three targets for the year — 10% electricity reduction, correct waste segregation on every ward, water-saving taps in public toilets — and a named owner for each. Monthly numbers went on a noticeboard.

AFTER

The Monitor reviewed the programme, the baseline, and six months of tracked data: electricity down 8%, waste segregation audited monthly at 90%+. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find last year's electricity, water, and waste bills — that is your baseline.
2. Walk the building at night: what is running that doesn't need to be?
3. Write three targets for this year, each with a number and a name.
4. Post the monthly figures somewhere staff can see them.

The most common mistake: Writing an environmental policy with no numbers — if you cannot say how much you used last month, you have no programme.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, written sustainability programme covering energy, waste, and resource use? — *A specific, documented programme, not a general statement of environmental values.*

Evidence: Sustainability programme document

2. Is progress tracked against defined, measurable targets? — *Real, trackable metrics, not an assumption that good intentions are sufficient.*

Evidence: Progress tracking data

3. Is there a named person or team responsible for the programme? — *Specific ownership, not diffuse responsibility that belongs to nobody in particular.*

Evidence: Role assignment record

COMMON REASONS FOR A PARTIAL ANSWER

- **A programme exists and covers energy well but waste and water use are addressed less specifically.** — Sustainability programmes often start with the most visible or easily measured area and expand unevenly.
- **Targets exist but tracking data hasn't been consistently collected to demonstrate progress against them.** — A target without consistent measurement can't actually demonstrate whether progress is happening.
- **The programme is genuinely active but was never formally documented in writing.**

IMPLEMENTATION PLAN

When	What
Week 1	Document current sustainability activities, even if informal, across energy, waste, and resource use.
Week 2	Set specific, measurable targets for the areas with the least current attention.
Week 3	Establish a tracking process and name a specific owner for the programme.
Ongoing	Review progress against targets on a fixed schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Programme document review	Reviews the sustainability programme for specificity across energy, waste, and resource use.
DOCUMENT	Progress tracking check	Reviews tracked data against defined targets for genuine, measurable progress.
ASK	Responsible person interview	Asks whoever owns the programme to describe current initiatives and real progress specifically.

SUPERVISOR TIPS

- **Ask for actual tracked data, not a description of good intentions.** — Measurable progress is the real evidence of a genuine, not aspirational, programme.
- **Ask about waste and water specifically, not just energy.** — Programmes often develop unevenly, and less-visible areas can lag behind.

EVIDENCE BASE

Environmental sustainability and climate resilience programmes are an emerging but increasingly established requirement across international healthcare accreditation frameworks, reflecting both direct environmental impact and operational resilience considerations.

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3.6 Facility Signage Is Complete, Not Just Present at Reception

NON-NEGOTIABLE

Evacuation routes, emergency exits, restrooms, and procedure or department doors are clearly and consistently signed throughout the facility — not only the entrance and

reception area covered under wayfinding, and not assumed adequately covered by evacuation drills alone.

In plain terms: Signs for exits, evacuation routes, toilets, and every department are present and consistent throughout the whole building — not just at the front door.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Wayfinding (criterion 1.5) is about a visitor finding their way. This criterion is about completeness and safety: can anyone, anywhere in the building, find an emergency exit? Are procedure rooms labelled so a patient is not wheeled into the wrong one? Are toilets signed in every wing, not just the lobby? Signage failures cluster in the back of buildings — service corridors, older wings, basements — exactly where staff go least and where a fire or a lost patient is hardest to manage. Consistent signage also matters for safety in a specific way: in smoke, in the dark, in panic, people follow familiar patterns. Mixed signage styles break that.

WHAT GOOD LOOKS LIKE

- Evacuation routes and exits are clearly signed throughout the entire facility, not just near the entrance.
- Restroom and department labelling is consistent throughout, using the same clear convention.
- Signage is periodically inspected and maintained, with a documented schedule.

COMMON FAILURE MODES

- Evacuation signage is strong near the entrance but sparse or absent in deeper parts of the building.
- Labelling conventions vary noticeably between departments or building sections.
- Signage is installed once with no ongoing inspection, and visible damage or fading goes unaddressed.

WORKED EXAMPLE

IN PRACTICE

A 170-bed hospital built in three phases over 30 years, each with different signage.

BEFORE	The lobby was well signed. The 1980s wing had exit signs that pointed to a door now locked and used for storage. The basement laboratory corridor had no exit sign at all. Two procedure rooms were unlabelled; a patient had recently been taken into the wrong one. Toilet signs existed in the lobby only.
ACTION	The Coordinator walked every corridor with the fire officer and a floor plan, marking every gap and every wrong sign. The locked exit was reopened as a genuine fire exit. Exit signs were installed in the basement and every corridor over 15 metres. All procedure rooms were numbered and named. Toilet signs went up in every wing. The signage style was standardised.
AFTER	The Monitor walked the basement and the old wing, found exits signed and routes clear, and every procedure room labelled. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Take a floor plan and walk every corridor, including the back ones. Mark every place you cannot see an exit sign.
2. Check every exit sign actually points to a door that opens.
3. List every procedure and department room without a sign.
4. Fix exits first, then procedure rooms, then toilets.

The most common mistake: Checking signage in the areas patients normally see and assuming the back of the building is the same.

SELF-ASSESSMENT QUESTIONS

1. Are evacuation routes and emergency exits clearly signed throughout the facility, not only near the main entrance? —
Comprehensive coverage — deep corridors, upper floors, less-trafficked

areas — not concentrated near reception.

Evidence: Photo audit of evacuation signage throughout the facility

2. Are restrooms and procedure or department doors clearly and consistently labelled? — *Consistent labelling convention throughout, not signage that varies by department or era of installation.*

Evidence: Signage consistency audit

3. Is signage periodically checked for damage, obstruction, or fading, not installed once and assumed permanent? — *Signage degrades over time and needs the same ongoing attention as any other safety measure.*

Evidence: Signage inspection schedule and record

COMMON REASONS FOR A PARTIAL ANSWER

- **Signage is comprehensive on the ground floor but thins out on upper floors or in older sections of the building.** — Signage completeness often reflects when different parts of a building were last renovated, not a deliberate consistent standard.
- **Evacuation routes are signed but restroom and department labelling wasn't part of the same signage review.** — A facility can focus on life-safety signage specifically and overlook general wayfinding signage as a separate, equally needed category.
- **An inspection schedule exists but hasn't caught a specific known issue, like a sign obscured by newly placed equipment.**

IMPLEMENTATION PLAN

When	What
Week 1	Walk the entire facility, not just entrance areas, and log every signage gap found.
Week 2	Prioritise and address evacuation route and exit signage gaps first.
Week 3	Standardise restroom and department labelling conventions throughout the facility.
Ongoing	Establish a periodic signage inspection schedule covering the whole building, not just high-traffic areas.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Comprehensive signage walk-through	Walks the full facility, including deep corridors and upper floors, checking evacuation route and exit signage completeness.
OBSERVE	Labelling consistency check	Checks restroom and department door labelling for consistency across different areas of the facility.
DOCUMENT	Inspection schedule review	Reviews the signage inspection schedule and recent inspection records for damage, obstruction, or fading.

SUPERVISOR TIPS

- **Walk deep into the building, not just the entrance and main corridors.** — Signage gaps concentrate exactly where a typical assessment visit might not naturally go.
- **Check for physical obstruction of existing signage, not just its initial presence.** — A sign that exists but is blocked by stored equipment provides no real protection.

EVIDENCE BASE

Facility signage completeness, including evacuation route marking throughout the building, is a distinct requirement from initial wayfinding and evacuation drill practice in international healthcare facility safety frameworks, reflecting that a drill tests staff response while signage protects anyone in the building at any time.

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← **Hospital Standards — all standards**

Self-assess against these criteria →

← **Standard 2 — Reception
& Information**

**Standard 4 — Care &
Treatment** →

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