

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

Standard 4 — Care & Treatment

37 criteria · 28 non-negotiable · 9 core · Version 3.0

CRITERIA IN THIS STANDARD

This standard is published in two parts because of its length.
Criteria 4.19–4.37: [Part 2](#) →

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

4.1 Consent Is Real, Not a Signature

NON-NEGOTIABLE

Informed consent explains risks, benefits, and alternatives before every significant procedure — a genuine conversation the patient can describe back, not a form signed on the way into theatre.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A signature on a consent form is not consent. Consent is understanding — the patient knows what will be done, what could go wrong, and what else they could choose. Without that, a bad outcome becomes a betrayal, not a known risk accepted. Legally, in almost every jurisdiction, a signed form obtained without genuine explanation is not valid consent, and courts increasingly ask what the patient was actually told. Clinically, patients who understand their procedure

recover better and follow instructions more closely. The test is not the form; it is whether the patient, asked ten minutes later, can describe the risks in their own words.

WHAT GOOD LOOKS LIKE

- A patient describes their procedure and its main risk accurately, in their own words.
- Consent forms show alternatives were discussed, not just the chosen procedure listed.
- Consent is routinely obtained with enough lead time to allow real reconsideration.

COMMON FAILURE MODES

- A patient can only repeat the procedure's name, with no understanding of risk.
- Consent forms are identical boilerplate with no evidence of individualised discussion.
- Consent is obtained minutes before the procedure, as a matter of routine.

WORKED EXAMPLE

IN PRACTICE

A 200-bed hospital where surgical consent is obtained on the morning of surgery by a junior doctor.

BEFORE

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

ACTION

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

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Can a patient who signed a consent form in the last month describe, in their own words, what the procedure involves? — *Not whether they signed — whether they understood.*
Evidence: Patient interview, or documented consent conversation notes
2. Are risks, benefits, and at least one alternative documented as discussed, not just the procedure name? — *A generic form listing the procedure only, with no discussion recorded, does not meet this.*
Evidence: Consent form plus conversation record
3. Is consent taken far enough in advance that a patient could realistically change their mind? — *Consent obtained on the trolley outside theatre is not meaningfully free.*
Evidence: Timing record

COMMON REASONS FOR A PARTIAL ANSWER

- **Consent is taken by whoever is available, not the person actually performing the procedure.** — A junior staff member relaying information secondhand often can't answer real questions.
- **The form is thorough but nobody checks the patient actually understood it.** — Literacy, language, and anxiety all affect comprehension in ways a signature can't reveal.

- **Consent happens early for the form, but the real conversation happens later, unrecorded.**

IMPLEMENTATION PLAN

When	What
Week 1	Review a sample of recent consent forms for evidence of real discussion versus boilerplate.
Week 2	Brief staff who take consent on checking understanding directly — ask the patient to explain it back.
Week 3	Build consent timing into the pre-procedure schedule, not left to whenever there's a spare moment.
Ongoing	Spot-check patient understanding periodically, not only when something goes wrong.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Patient understanding check	Asks a recently consented patient, separately from staff, to describe the procedure and its main risk in their own words.
DOCUMENT	Consent record review	Reviews a sample of consent forms for evidence of a real discussion — risks, alternatives, and questions — not just a signature line.
OBSERVE	Timing check	Checks when consent is typically obtained relative to the procedure, looking for last-minute, pressured timing as a pattern.

SUPERVISOR TIPS

- **Ask the patient before looking at the form.** — Their own account, unprompted by the paperwork, reveals what they actually retained.
- **Check who is named as taking consent versus who actually performs the procedure.** — A mismatch is a common, quiet failure point.

EVIDENCE BASE

[40] WHO's Guidelines for Safe Surgery identify complete, understood consent as a precondition of the pre-induction checklist step, not a separate administrative task.

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4.2 Staff Credentials Are Checked and Current

NON-NEGOTIABLE

Every clinical staff member's qualifications are verified and on file — checked directly with the issuing or licensing body, not taken on the applicant's word — and that staff member receives structured orientation before independent practice, periodic performance and competency evaluation thereafter, and is expected to practise according to current, accepted evidence-based standards, protocols and guidelines.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Fake medical degrees and forged nursing licences are not rare. Every year, unqualified individuals are found practising in hospitals that accepted a photocopy and never checked. The harm to patients is obvious; the harm to the hospital — legal, financial, reputational — can be fatal. Verification means contacting the university, the licensing board, or the registry and confirming: this person, this qualification, this date. It takes an email. Not doing it means the hospital has no idea

who is actually treating its patients. 'Current' matters too: licences lapse, registrations expire, and a nurse practising on an expired licence exposes the hospital equally.

WHAT GOOD LOOKS LIKE

- A clear, current verification record exists for each clinical staff member, checked directly with the issuer.
- A named person owns credential tracking and can describe the process confidently.
- Renewals are tracked proactively, not discovered as overdue by accident.

COMMON FAILURE MODES

- Staff files contain photocopied certificates with no evidence anyone contacted the issuing body.
- Nobody can say who is responsible for credentialing when asked directly.
- A lapsed credential is discovered only when this question is asked, not through routine tracking.

WORKED EXAMPLE

IN PRACTICE

A 110-bed hospital with 85 clinical staff and an HR file for each.

BEFORE	Each file contained a photocopied degree and licence. Nobody had contacted an issuing body. The Coordinator picked ten files at random and checked with the medical council: nine confirmed, one physician's registration had lapsed 14 months earlier. He was still prescribing.
ACTION	HR was given a verification form: for each clinical staff member, the issuing body was contacted and the response filed. Every licence expiry date went into a spreadsheet with a 60-day reminder. The lapsed physician was suspended from clinical duties until re-registered.
AFTER	The Monitor sampled 15 files: each had a written confirmation from the issuing body and a current licence. The expiry spreadsheet showed no lapses. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Is every clinical staff member's licence or qualification verified directly with the issuing body? — *A photocopied certificate on file is not verification — contacting the issuer is.*

Evidence: Verification record per staff member

2. Are credentials rechecked on renewal, not just at hiring? — *A licence can lapse or be revoked after hiring without anyone noticing if it's never rechecked.*

Evidence: Renewal tracking log

3. Is there a named person responsible for credential tracking, not an informal arrangement? — *Responsibility spread across nobody in particular usually means it happens to nobody in particular.*

Evidence: Role assignment record

4. Does every new clinical staff member complete structured orientation covering role-specific procedures before practising independently? — *A real, structured orientation programme, not an assumption that shadowing a colleague for a few days is sufficient.*

Evidence: Orientation completion record

5. Is every clinical staff member's performance and competency formally evaluated on a defined schedule, documented and shared with the staff member? — *A genuine, documented, periodic evaluation process, distinct from credential verification alone.*

Evidence: Performance evaluation record

6. Can staff describe the current evidence-based guideline or protocol behind a specific clinical decision they made recently? —
Genuine, demonstrated reliance on current accepted evidence, not inherited practice never revisited.
Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happened once, at hiring, years ago, with no renewal check since.** — A licence current at hiring says nothing about its status now.
- **Responsibility for credentialing sits with someone who has since left, informally.** — Nobody deliberately dropped it — it just had no clear owner after a staff change.
- **Verification happens for doctors but not consistently for nurses or allied staff.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit current staff files for evidence of direct verification versus filed copies.
Week 2	Contact issuing bodies directly for any credential not yet verified this way.
Week 3	Name one person as owner of ongoing credential tracking, with it in their actual job description.
Ongoing	Build renewal dates into a simple calendar or tracker, checked monthly.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Verification record check	Selects a sample of staff files and checks for evidence of direct verification with the issuing body, not just a filed copy.
ASK	Responsible person interview	Asks whoever is named as responsible for credentialing to describe the actual verification process, not the policy on paper.

Method	What	Detail
OBSERVE	Renewal tracking check	Checks whether any staff credential is currently overdue for renewal without a tracked follow-up.

SUPERVISOR TIPS

- **Ask for the verification record, not the certificate.** — A certificate proves the applicant had a document; a verification record proves someone checked it was real.
- **Pick a staff member at random, not one the facility suggests.** — A prepared example proves less than a genuinely random check.

EVIDENCE BASE

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

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4.3 New Staff Are Properly Onboarded

NON-NEGOTIABLE

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

In plain terms: New clinical staff complete a defined induction — with a checklist — before working independently, covering safety essentials, not just ‘watch and learn.’

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The first weeks are when new staff cause the most harm: they do not know where the resuscitation trolley is, which drugs are stored where, how to raise an alarm, who to call at night. Learning by watching a colleague transfers habits — good and bad — with no guarantee that anything essential is covered. A checklist-based induction ensures that every new nurse knows the fire exits, the hand hygiene policy, the medication double-check process, and the incident reporting system before they are alone with a patient. It also protects the hospital: a signed induction record is evidence that the essentials were taught.

WHAT GOOD LOOKS LIKE

- A specific, checklist-based induction is completed before independent work begins.
- A new staff member can describe real safety content from their induction, not just that it happened.
- Induction timing consistently precedes unsupervised work, verified by record.

COMMON FAILURE MODES

- Induction is a general welcome with no specific safety checklist.
- A new staff member cannot recall any specific safety content from their induction.
- Independent work begins before induction is documented as complete.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital that recruits 20–30 nurses a year with high turnover.

BEFORE

New nurses were paired with an experienced colleague for a week and then rostered independently. No checklist. The Coordinator asked three nurses with under three months' service where the resuscitation trolley was on their ward; two did not know. None had been shown the incident reporting system.

ACTION

The Coordinator built a two-page induction checklist: 25 safety essentials, each with a sign-off from the inductee and the supervisor. It

included a walk to the resus trolley, a demonstration of the incident form, and a hand hygiene observation. No new clinical staff member could be rostered alone until the checklist was complete and filed.

AFTER

The Monitor reviewed six recent induction files, all complete and signed. Asked two new nurses to locate the resus trolley and describe incident reporting; both did so correctly. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask your three newest clinical staff where the resuscitation equipment is and how to report an incident.
2. List the 20 things a new nurse must know before their first solo shift.
3. Turn it into a checklist with two signatures per item.
4. Make it a roster rule: no solo shifts until the checklist is filed.

The most common mistake: Calling a week of shadowing 'induction' — shadowing has no content guarantee.

SELF-ASSESSMENT QUESTIONS

1. Is there a documented induction checklist covering safety essentials before independent work? — *Not a general welcome session — specific safety content, checked off item by item.*

Evidence: Induction checklist, completed and signed

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

Evidence: Timing record against start date

3. Can a recently hired staff member describe what their induction actually covered? — *A completed checklist with no real retention suggests a formality, not real training.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A checklist exists but is completed retroactively, after work has already begun.** — The paperwork catches up eventually; the actual

unsupervised gap already happened.

- **Induction covers policy but not the specific hazards of this facility.** — Generic safety content misses the facility-specific risks a new hire actually needs to know.
- **Senior staff are exempted from induction because they’re “experienced.”**

IMPLEMENTATION PLAN

When	What
Week 1	Draft a specific, checklist-based induction covering this facility’s actual safety essentials.
Week 2	Assign a named person to deliver and sign off induction for every new hire, no exceptions.
Week 3	Test the induction on a current staff member — can they recall the content afterward?
Ongoing	Review and update the induction checklist whenever a new hazard or protocol change occurs.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Induction checklist review	Reviews the induction checklist for specific, checkable safety content, not generic orientation topics.
ASK	New staff interview	Asks a recently hired staff member what their induction actually covered, independently of the checklist.
OBSERVE	Timing verification	Checks the gap between hire date and induction completion against the date independent work began.

SUPERVISOR TIPS

- **Ask the newest hire, not a convenient example.** — The most recent hire’s experience is the freshest, most accurate test of current practice.
- **Ask what they’d do in a specific scenario, not just what the checklist covered.** — Retained understanding shows in application, not recitation.

EVIDENCE BASE

Induction and orientation quality is repeatedly identified in patient safety literature as a modifiable factor in early-tenure adverse events, distinct from formal qualification.

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4.4 Staffing Actually Matches Patient Need

NON-NEGOTIABLE

Staffing levels and skill mix are documented against real patient volume and acuity — a calculation grounded in actual demand, not a fixed roster set once and never revisited.

In plain terms: Staffing numbers and skills are worked out from how many patients you actually have and how sick they are — and adjusted — not fixed once and never revisited.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Understaffed wards kill patients. This is one of the best-evidenced findings in health services research: each additional patient per nurse increases mortality measurably. But staffing is rarely calculated — it is inherited. The roster was set years ago for a ward that has since changed its case mix, its bed count, or its procedures. A hospital that cannot show how it arrived at its staffing levels cannot show they are safe. The standard does not prescribe a ratio; it asks for a method: a documented calculation from real volume and acuity, reviewed when things change.

WHAT GOOD LOOKS LIKE

- Staffing is calculated against documented,

COMMON FAILURE MODES

- The roster hasn't been recalculated against real

current patient volume and acuity data.

- A clear, used escalation process exists for staffing shortfalls.
- Staff describe a real, specific process for short-staffed situations, not improvisation.

patient data in years.

- No escalation process exists — shortfalls are absorbed silently.
- Staff describe managing shortfalls through informal overtime with no tracked pattern.

WORKED EXAMPLE

IN PRACTICE

A 120-bed hospital whose medical ward roster had not changed in six years.

BEFORE

The ward had 28 beds and 3 nurses per shift, set when average occupancy was 18. Occupancy was now 26 and the ward had taken on post-surgical patients. Nurses reported missed medication rounds and unanswered call bells. No document explained the 3-nurse figure.

ACTION

The Coordinator and matron recorded four weeks of daily occupancy and a simple acuity score per patient. They used a recognised dependency tool to calculate required nursing hours, compared it to rostered hours, and found a 30% shortfall on day shifts. The Director approved one additional nurse per day shift. The calculation was documented and a quarterly review scheduled.

AFTER

The Monitor reviewed the calculation, the roster change, and two quarterly reviews. Asked ward nurses about workload; they described the improvement. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For your busiest ward, record daily occupancy and a rough acuity score for four weeks.
2. Ask: when was this roster last calculated, and from what?

3. Use any recognised nursing dependency tool to estimate required hours.
4. Compare to rostered hours, document the gap, and take it to the Director.

The most common mistake: Defending a roster because ‘we’ve always managed’ — managing is not the same as safe.

SELF-ASSESSMENT QUESTIONS

1. Is staffing calculated against actual, current patient volume and acuity, not a fixed historical roster? — *A roster set years ago and never revisited doesn’t reflect today’s real demand.*

Evidence: Staffing methodology document

2. Is there a defined process for escalating when staffing falls short of documented need? — *Recognising a shortfall is only useful if something happens as a result.*

Evidence: Escalation protocol

3. Can staff describe what happens when they’re short-staffed, beyond “we manage”? — *A vague answer usually means there’s no real process, just accumulated coping.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Staffing was calculated correctly once but never revisited as patient volume changed.** — A methodology that was sound at inception can become stale without anyone deciding to abandon it.
- **An escalation process exists on paper but staff don’t know it or use it.** — A policy nobody uses functions identically to no policy at all.
- **Acuity is tracked for some patients but not systematically across the whole unit.**

IMPLEMENTATION PLAN

When	What
Week 1	Compare current rosters against actual recent patient volume and acuity data.
Week 2	Identify the gap, if any, between documented staffing methodology and real practice.

When	What
Week 3	Build or revise a simple, usable escalation process for shortfalls, and brief all staff on it.
Ongoing	Revisit the staffing calculation on a fixed schedule, not only when a crisis forces the question.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Staffing methodology review	Reviews how staffing levels are calculated and whether the calculation reflects actual, current patient volume and acuity.
ASK	Front-line escalation interview	Asks front-line staff what actually happens when a shift is short-staffed relative to patient need.
OBSERVE	Roster-to-census comparison	Compares recent rosters against actual patient census and acuity data to check for a real, tracked relationship.

SUPERVISOR TIPS

- **Ask staff directly, not management, what happens when short-staffed.** — Management's description of the escalation process and staff's lived experience of it can diverge significantly.
- **Look at a real shift's data, not an idealised average.** — Averages can hide genuinely dangerous individual shifts.

EVIDENCE BASE

[4] Aiken et al.'s research on nurse staffing ratios and patient outcomes is among the most replicated findings in health services research, linking staffing levels directly to mortality and complication rates.

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4.5 Hand Hygiene Actually Happens

NON-NEGOTIABLE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

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

WHAT GOOD LOOKS LIKE

- Hand hygiene stations are present exactly where care happens, fully stocked, consistently.
- Unannounced observation shows genuine compliance at key moments, not just when watched.
- Supply levels are consistent regardless of whether a visit is

COMMON FAILURE MODES

- Stations exist only at ward entrances, far from where actual patient contact happens.
- Compliance visibly drops the moment staff believe they're unobserved.
- Stations are conspicuously restocked only ahead of scheduled inspections.

scheduled or
unannounced.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital with alcohol rub dispensers at ward entrances only.

BEFORE

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

ACTION

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

AFTER

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

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

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

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

SELF-ASSESSMENT QUESTIONS

1. Are hand hygiene stations physically present at the actual point of care, not just at ward entrances? — *A station at the entrance to a ward doesn't help at the bedside where contact actually happens.*

Evidence: Photo audit of station placement

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

Evidence: Unannounced observation audit data

3. Is there a visible difference in supply availability between announced and unannounced checks? — *Stations mysteriously well-stocked only during scheduled inspections is a specific, real failure pattern.*

Evidence: Supply log across different dates

COMMON REASONS FOR A PARTIAL ANSWER

- **Stations exist everywhere but are frequently empty between restocking cycles.** — Infrastructure without reliable maintenance produces the same gap as no infrastructure.
- **Compliance is genuinely good for some of the Five Moments but not others.** — Before touching a patient is often well internalised; after touching surroundings near a patient often is not.
- **New staff comply well immediately after induction, then drift over time.**

IMPLEMENTATION PLAN

When	What
Week 1	Map actual point-of-care locations against current hand hygiene station placement, and identify gaps.
Week 2	Fix placement gaps and establish a restocking schedule with a named owner.
Week 3	Conduct a genuine, unannounced baseline observation audit using the WHO Five Moments framework.
Ongoing	Repeat unannounced audits periodically — announced-only auditing measures compliance theatre, not compliance.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Point-of-care station check	Physically verifies hand hygiene stations exist at the actual point of care, not only at ward entrances.
OBSERVE	Unannounced compliance observation	Conducts genuine, unannounced observation of hand hygiene practice at the WHO's Five Moments, without alerting staff in advance.
DOCUMENT	Supply consistency check	Compares supply and stocking records across announced and unannounced dates for evidence of "inspection-only" stocking.

SUPERVISOR TIPS

- **Never announce the observation in advance, even implicitly.** — Staff behaviour changes measurably the moment they suspect they're being watched for this specific thing.
- **Check supply logs across multiple dates, not just the visit day.** — A single well-stocked day proves nothing about routine practice.

EVIDENCE BASE

[41] WHO's Guidelines on Hand Hygiene in Health Care (2009) established the "Five Moments for Hand Hygiene" framework, now the global reference standard, with compliance directly linked to reduced healthcare-associated infection rates.

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4.6 Protective Equipment Is Actually Available

NON-NEGOTIABLE

PPE is accessible at the point of use, not stored in a locked room or a location that adds friction between the need and

the use.

In plain terms: Gloves, masks, gowns and eye protection are right there where staff need them — not in a locked store or a different building.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Every step between a nurse and a pair of gloves is a step where the gloves will not be worn. If PPE is in a locked cupboard, behind a requisition form, or on another floor, staff will do the task without it — not from carelessness but because the patient is here and the cupboard is there. This exposes staff to bloodborne pathogens and spreads infection between patients. The standard is deliberately about friction: PPE must be at the point of use, stocked, and free to take. Stock control is a real concern, but the answer is better stock management, not locking the supply away from the people who need it.

WHAT GOOD LOOKS LIKE

- PPE is available exactly where needed, with no locks or distance barriers to access.
- PPE type matches the specific risk profile of each area.
- Stock monitoring prevents mid-shift stockouts, with a clear resupply process.

COMMON FAILURE MODES

- PPE is stored in a locked area requiring a key held by one person, often unavailable.
- The same generic PPE kit is provided everywhere regardless of actual risk.
- Staff report having run out of a specific item mid-shift with no immediate resupply.

WORKED EXAMPLE

IN PRACTICE

A 100-bed hospital where PPE was held in a central store to prevent waste.

BEFORE

Gloves and masks were issued in boxes by requisition from the central store, open 8am–

	4pm. Wards ran out on weekends. The Coordinator observed a dressing change done without gloves because the ward box was empty and the store was closed. Staff described 'saving' gloves for procedures they considered high-risk.
ACTION	Each ward received a PPE station near the nurse's desk, restocked daily by the store to a par level. Treatment rooms and isolation rooms had their own supply. Stock use was tracked by ward so the store could see real consumption rather than guess. Staff were told explicitly: PPE is not rationed.
AFTER	The Monitor checked all ward PPE stations at 7am on a Saturday: all stocked. Observed three procedures, all with appropriate PPE. Stock records showed consistent daily restocking. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk to your nearest patient bay and count the steps to a box of gloves.
2. Check every ward at a weekend — is PPE stocked?
3. Set a par level per ward and restock daily to it, not on request.
4. Tell staff in writing that PPE is not rationed.

The most common mistake: Locking PPE away to control costs, then wondering why staff don't use it.

SELF-ASSESSMENT QUESTIONS

1. Is PPE physically accessible at the point of use, without requiring a key or a walk to another area? — *Locked storage or distant supply points reduce actual use regardless of stock levels.*

Evidence: Photo audit of PPE accessibility

2. Is appropriate PPE available for the specific transmission risk of each area, not a generic kit everywhere? — *A one-size-fits-all approach often means the wrong equipment is available where a specific*

risk exists.

Evidence: PPE type mapping by area

3. Is stock monitored so that PPE doesn't run out mid-shift? — A stockout discovered mid-procedure is a preventable failure, not a supply chain inevitability.

Evidence: Stock monitoring log

COMMON REASONS FOR A PARTIAL ANSWER

- **PPE is accessible during the day shift but locked overnight for security reasons.** — A security decision made independently of infection control creates a genuine access gap at specific times.
- **Stock exists in the building but not distributed to where it's actually used.** — Central storage without point-of-use distribution reproduces the accessibility problem.
- **Reordering happens reactively, after a stockout, rather than on a proactive schedule.**

IMPLEMENTATION PLAN

When	What
Week 1	Map every point of use against current PPE storage locations and identify friction points.
Week 2	Relocate or duplicate PPE stock to eliminate locks and distance barriers at point of use.
Week 3	Match PPE type to the actual risk profile of each specific area.
Ongoing	Move to proactive, scheduled reordering rather than reactive restocking after a shortage.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Point-of-use accessibility check	Checks whether PPE is genuinely accessible at the point of use without added friction — locked doors, distant storage.
OBSERVE	Area-appropriate stock check	Verifies the PPE available in each area matches the actual transmission risk of that area, not a generic standard kit.

Method	What	Detail
DOCUMENT	Stockout history review	Reviews stock monitoring records for evidence of past stockouts and whether any led to a documented response.

SUPERVISOR TIPS

- **Try to access PPE yourself, at the point of use, without staff assistance.** — Friction that staff have normalised through habit is often invisible until an outsider tries it.
- **Ask about overnight or weekend access specifically.** — Accessibility during a scheduled daytime visit doesn't prove accessibility at other times.

EVIDENCE BASE

[35] Standard and transmission-based precautions frameworks, including WHO infection prevention guidance, identify point-of-use accessibility as a determinant of actual PPE use, independent of stock levels.

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4.7 Sharps and Waste Are Handled Safely

NON-NEGOTIABLE

Clinical waste and sharps are segregated and disposed of safely at the point of use, with containers appropriately placed rather than requiring staff to carry hazardous material any distance.

In plain terms: Sharps bins and clinical waste containers are right where the sharp or waste is generated — so no one carries a used needle across a room.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Needlestick injuries happen in the seconds between using a sharp and disposing of it. Every metre carried is a metre of risk — to the nurse, and to anyone in between. Mixed waste is a second hazard: clinical waste in the general stream exposes cleaners and the community; general waste in the clinical stream costs money. The standard is about placement: a sharps bin within arm's reach of every point where sharps are used, at a height where the opening is visible, never overfilled. It is one of the cheapest safety measures in the hospital and one of the most often failed by convenience — one bin per room instead of one per bed.

WHAT GOOD LOOKS LIKE

- Sharps containers are present at every point of use, correctly placed and never requiring transport of an uncontained sharp.
- Containers are consistently replaced before reaching unsafe fill levels.
- Waste segregation happens correctly at the point of disposal, not sorted afterward.

COMMON FAILURE MODES

- Staff routinely carry used sharps to a distant disposal point.
- Containers are found filled well past the safe-fill line.
- Mixed waste requires manual re-sorting after disposal, exposing staff to already-contaminated material.

WORKED EXAMPLE

IN PRACTICE

A 130-bed hospital with one sharps bin per ward at the nurses' station.

BEFORE

Nurses carried used needles from bedsides to the station bin, sometimes 20 metres. The occupational health log showed six needlestick injuries in the previous year; four occurred during that walk. Bins were regularly filled past the line. Yellow clinical waste bags were found in general waste skips behind the kitchen.

ACTION

Wall-mounted sharps bins were installed at every bed and every trolley. A rule was set: bins are

sealed and replaced at the fill line, checked at each handover. Colour-coded waste bins with pictorial labels went into every clinical room. Cleaners and nurses had a 15-minute segregation refresher; a weekly waste audit began.

AFTER

The Monitor found sharps bins at every bed, none overfilled. Observed an injection with immediate disposal at the bedside. Waste audit showed 95% correct segregation. Needlesticks in the following six months: one. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Stand at a patient's bed and look for a sharps bin. If it isn't within reach, that is the gap.
2. Check your needlestick injury log — where did they happen?
3. Install a bin at every bed or trolley where sharps are used.
4. Look in the general waste skip for yellow bags.

The most common mistake: One sharps bin per ward — every needle carried across the ward is a needlestick waiting to happen.

SELF-ASSESSMENT QUESTIONS

- 1.** Are sharps containers available immediately at the point of use, not requiring staff to walk with an exposed sharp? — *Any distance travelled with an uncontained sharp is unnecessary risk.*

Evidence: Photo audit of container placement

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

Evidence: Replacement schedule and fill-level checks

- 3.** Is clinical waste segregated correctly at the point of disposal, not sorted later? — *Correct sorting after the fact requires someone to handle already-contaminated mixed waste.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Containers are correctly placed in main wards but missing in smaller or newer clinical areas.** — Coverage often reflects when an area was last reviewed, not deliberate risk assessment.
- **Replacement happens on a fixed schedule that doesn't account for high-volume days.** — A calendar-based schedule can lag behind actual usage on busy days.
- **Staff know the correct segregation rules but shortcuts happen under time pressure.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit every clinical area for sharps container placement relative to actual point of use.
Week 2	Add or relocate containers to close any gaps found.
Week 3	Move from calendar-based to fill-level-triggered replacement where volume is unpredictable.
Ongoing	Review any sharps injury or near-miss report specifically for a disposal-access root cause.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Container placement check	Verifies sharps containers are available at the actual point of use across multiple clinical areas, not centrally located.
OBSERVE	Fill-level check	Checks current fill levels of sharps containers in use against the safe-fill line.
DOCUMENT	Injury and near-miss log review	Reviews any sharps injury or near-miss reports for patterns related to disposal access or timing.

SUPERVISOR TIPS

- **Check fill levels directly, don't rely on staff assurance.** — A container reported as "fine" and a container actually below the safe-fill line are not always the same thing.
- **Look in smaller, less-visited clinical areas, not just main wards.** — Coverage gaps concentrate in spaces reviewed less often.

EVIDENCE BASE

[39] WHO's guidance on safe injection practices and healthcare waste management identifies point-of-use sharps disposal as a core preventable-injury control measure, not an optional refinement.

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4.8 Every Patient Gets a Real Assessment

NON-NEGOTIABLE

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

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The admission assessment is where you find the things that will kill the patient if missed: the allergy, the anticoagulant, the pressure sore already forming, the fall last week, the confusion that is actually sepsis. A structured assessment forces the clinician to look for each of these systematically. An unstructured one relies on the clinician remembering to ask — and under pressure, they do not. Documentation that is complete but done by copying the referral letter is worse than none, because it looks like an assessment happened. The test is whether the assessment finds things the patient did not volunteer.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- A structured assessment tool is used consistently, completed within a defined timeframe.
 - Assessments show patient-specific findings and reasoning, not templated language.
 - Clinicians can explain their reasoning behind specific findings when asked.
- Assessment entries are free text only, with no structured tool in use.
 - Assessments are frequently completed well outside any defined timeframe.
 - Multiple patients' assessments show identical or near-identical wording.

WORKED EXAMPLE

IN PRACTICE

A 160-bed hospital where admission assessments were a free-text note in the medical record.

BEFORE	The Coordinator reviewed 20 recent admission notes. Twelve had no documented allergy check. Eight had no falls history. Six had no medication list. Three patients had pressure injuries documented by nurses on day two that were not noted on admission. Doctors said they 'assessed everything' but the notes did not show it.
ACTION	A one-page structured admission template was introduced: allergies, medications, falls, pressure risk, nutrition, VTE risk, cognition, and reason for admission — each with a mandatory field. It was piloted on one ward for two weeks, revised, then rolled out. The template became the first page of every admission record.
AFTER	The Monitor reviewed 20 recent admissions: all used the template with all fields completed. Two showed allergies discovered at admission that the referral had not mentioned. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 20 recent admission notes and check: allergy, medications, falls, pressure risk — how many are documented?

2. Ask one admitting doctor to walk you through their assessment; note what they skip.
3. Build a one-page template covering the eight essentials.
4. Pilot it on one ward, then make it the first page of every record.

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

SELF-ASSESSMENT QUESTIONS

1. Is a structured assessment tool used on admission, not a free-text chart entry alone? — *A structured tool ensures systematic coverage regardless of who is completing it or how busy they are.*

Evidence: Assessment tool and completed sample

2. Does the assessment happen within a defined timeframe of admission, not “eventually”? — *An assessment completed a day late has already missed its window to catch early risk.*

Evidence: Timing record against admission time

3. Is the assessment specific to the patient, or does it show signs of being copied from a previous entry? — *Identical wording across different patients’ assessments signals a formality, not a real evaluation.*

Evidence: Sample comparison across patients

4. Is the assessment genuinely performed by someone qualified to perform it, verifiable against that person’s credentialed scope? — *A named, qualified assessor, not an assessment completed by whoever happened to have a free moment.*

Evidence: Assessor credential/scope record

5. Where the patient’s presentation calls for it, does the initial assessment genuinely draw in other relevant disciplines? — *Real multidisciplinary input when the case warrants it, not a single-discipline assessment applied uniformly regardless of need.*

Evidence: Multidisciplinary consult record

COMMON REASONS FOR A PARTIAL ANSWER

- **A structured tool exists but sections are routinely left blank under time pressure.** — Partial completion under pressure often defaults to skipping the sections that take longest to think through properly.

- **Assessment happens on time for planned admissions but lags for unplanned or emergency ones.** — The busiest, highest-risk admissions are often exactly where the process breaks down first.
- **Senior clinicians complete genuine assessments; junior staff sometimes copy forward.**

IMPLEMENTATION PLAN

When	What
Week 1	Review a sample of recent assessments for genuine, patient-specific content versus templated language.
Week 2	Set and communicate a clear timeframe for assessment completion after admission.
Week 3	Brief clinical staff specifically on the risk of copy-forward documentation.
Ongoing	Spot-check assessment quality periodically, particularly for unplanned admissions.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Assessment tool review	Reviews the structured assessment tool used and checks a sample of completed assessments for genuine, patient-specific content.
OBSERVE	Timing compliance check	Checks the gap between admission time and assessment completion across a sample of recent admissions.
ASK	Clinician interview	Asks the clinician who completed a specific assessment to explain their reasoning for a particular finding, testing genuine engagement versus rote completion.

SUPERVISOR TIPS

- **Compare assessments across different patients, not just check they exist.** — Identical wording across patients is the clearest possible sign of a copy-forward habit.
- **Ask the clinician to explain one specific finding, not to summarise the whole assessment.** — Specific questions reveal

genuine engagement in a way general ones don't.

EVIDENCE BASE

Structured admission assessment is a foundational element of clinical governance frameworks across major health systems, directly linked to earlier detection of deterioration risk.

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4.9 There's an Actual Care Plan

NON-NEGOTIABLE

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

In plain terms: Every patient has a written care plan built from their own assessment — not a generic template that says the same thing for everyone.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A care plan is how the assessment turns into action, and how the night shift knows what the day shift intended. Without one, care is improvised by whoever is on duty. A generic plan — the same wording for every pneumonia, every hip fracture — is not a plan; it is a policy pasted into the record. The patient with the pressure injury needs a turning schedule; the one with the fall history needs a low bed and a bell within reach; the one who is confused needs orientation cues. If the plan does not mention them, the assessment was wasted. A plan is individualised when it could not be swapped with another patient's without someone noticing.

WHAT GOOD LOOKS LIKE

- Care plans reflect genuinely individual assessment findings, not generic templates.
- Plans are visibly updated as patient condition changes, with a clear revision history.
- Staff taking over a shift find and understand the current plan quickly and confidently.

COMMON FAILURE MODES

- Care plans for different patients with similar diagnoses read identically.
- A plan remains unchanged despite documented deterioration or improvement.
- Staff report difficulty locating or understanding the care plan at handover.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital using pre-printed care plans by diagnosis.

BEFORE

The Coordinator pulled ten care plans from the medical ward. Six were identical except for the name. A patient with a documented fall risk had no fall precautions in her plan. A diabetic patient's plan did not mention glucose monitoring. Nurses said the plans were 'for the records' and they worked from the handover sheet.

ACTION

The Coordinator replaced pre-printed plans with a structured blank: for each problem identified at assessment, the goal, the actions, and who does them. Nurses were trained in a 30-minute session to write plans from the assessment. Plans were reviewed at each handover and updated. A weekly audit checked five plans against their assessments.

AFTER

The Monitor reviewed ten plans: each addressed the specific problems in that patient's assessment. Asked a night nurse how she knew what a patient needed; she pointed to the plan. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull five care plans and cover the names — could you tell which patient is which?
2. Compare each plan to that patient's assessment: does every identified problem have an action?
3. Ask a nurse what document they actually use to plan care.
4. Replace pre-printed plans with a problem → goal → action structure.

The most common mistake: Using diagnosis-based template plans that do not reflect what the assessment actually found.

SELF-ASSESSMENT QUESTIONS

1. Is there a documented care plan specific to this patient's assessment findings, not a generic template? — *A plan that could apply to any patient with a similar diagnosis, unchanged, suggests it wasn't individualised.*

Evidence: Care plan sample

2. Does the care plan get updated as the patient's condition changes, not written once and left static? — *A care plan that never changes despite documented changes in condition has stopped functioning as a plan.*

Evidence: Care plan revision history

3. Can a staff member taking over a shift find and understand the current care plan quickly? — *A plan that's hard to locate or interpret at handover fails at the exact moment it matters most.*

Evidence: N/A — tested directly

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

Evidence: Care plan goal documentation

5. Was the patient, and family where appropriate, genuinely involved in setting the plan's goals? — *Real involvement in setting direction, not notification after the plan is already fixed.*

Evidence: Patient/family interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Care plans are individualised at creation but rarely revisited afterward.** — A good plan on day one that never gets updated becomes a stale plan by day five.
- **Plans exist in a system that's hard to navigate quickly during a busy handover.** — Good content in an inaccessible format functions poorly under real time pressure.
- **Revision happens for major changes but not smaller, cumulative ones.**

IMPLEMENTATION PLAN

When	What
Week 1	Compare a sample of care plans across similar diagnoses for genuine individualisation.
Week 2	Establish a clear expectation for when care plans must be revisited and updated.
Week 3	Test handover speed — can a staff member unfamiliar with a specific patient find and understand the plan quickly?
Ongoing	Audit plan currency periodically against documented condition changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Care plan individualisation check	Compares care plans across patients with similar diagnoses to check for genuine individualisation versus templated content.
DOCUMENT	Revision history review	Checks whether care plans are updated in response to documented changes in patient condition.
ASK	Handover staff interview	Asks a staff member who recently took over a shift how quickly and clearly they located and understood the current care plan.

SUPERVISOR TIPS

- **Compare plans side by side, not one at a time.** — Templating is far more visible in direct comparison than in isolated review.
- **Time how long it takes staff to locate a plan during a simulated handover.** — Speed and clarity under time pressure is the real test, not eventual retrievability.

EVIDENCE BASE

Individualised, documented care planning is consistently associated with improved continuity of care across shift changes in health services literature, distinct from assessment quality alone.

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4.10 Medication Prescribing Is Safe

NON-NEGOTIABLE

Prescriptions are checked, legible, and follow a defined safety process — including a genuine second check for high-risk medications by a trained, designated person, whoever that is at this facility, not reliance on one clinician's judgement alone.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Adapted	Full	Full

WHY THIS MATTERS

Medication errors are the most common preventable harm in hospitals. Most originate at prescribing: illegible handwriting, wrong dose, wrong unit, missed interaction, missed allergy. A second check catches the majority — but only if it is a real check by someone trained to know what to look for, not a signature from whoever is nearest. High-risk medications — insulin, anticoagulants, opioids, chemotherapy,

concentrated electrolytes — deserve a mandatory independent double-check because a single error can kill. The process must be defined: who checks, what they check, how it is recorded.

WHAT GOOD LOOKS LIKE

- Prescriptions are consistently legible, complete, and unambiguous.
- A defined, genuinely followed second-check process exists for high-risk medications.
- Caught errors are tracked and reviewed, feeding back into practice.

COMMON FAILURE MODES

- Prescriptions are frequently illegible or missing key information.
- No specific second-check process exists for high-risk medications beyond general care.
- Caught errors are corrected silently with no tracking or review.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital with handwritten prescriptions and no defined checking process.

BEFORE

The Coordinator reviewed 50 prescription charts. Seven had entries the pharmacist could not read. Four had no route. Two had a dose in mg where mcg was intended. There was no list of high-risk drugs and no second-check requirement. Nurses said they 'checked with each other sometimes.'

ACTION

A prescribing standard was written: printed name, drug, dose, route, frequency, and signature on every entry; unclear entries returned unfilled. A high-risk drug list (eight classes) was posted in every clinical area with a mandatory two-signature check before administration. Pharmacy began a daily review of all new prescriptions on two pilot wards.

AFTER

The Monitor reviewed 40 charts: all legible and complete. Observed an insulin administration with independent double-check. Pharmacy

intervention log showed 30 errors caught in two months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 30 prescription charts and check: can a pharmacist read every entry? Is every dose, route and frequency present?
2. Write a list of the eight to ten high-risk drug classes and post it in every clinical area.
3. Require two signatures before any high-risk drug is given.
4. Ask pharmacy to review new prescriptions on one ward for a month and log what they catch.

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

SELF-ASSESSMENT QUESTIONS

1. Are prescriptions legible and complete, including dose, route, and frequency, without ambiguity? — *An illegible or incomplete prescription forces the dispensing or administering staff to guess or assume.*

Evidence: Prescription sample review

2. Is there a defined second-check process for high-risk medications specifically? — *General vigilance is not the same as a specific, mandatory second check for the medications most likely to cause serious harm.*

Evidence: Second-check protocol

3. Are prescribing errors, when caught, tracked and reviewed, not just quietly corrected? — *A caught error that's never reviewed teaches the system nothing about why it happened.*

Evidence: Error tracking log

COMMON REASONS FOR A PARTIAL ANSWER

- **A second-check process exists on paper but is skipped under time pressure.** — A safety step that depends entirely on unhurried conditions will fail exactly when it's needed most — during a busy shift.
- **Legibility is good for regular prescribers but poor for occasional or covering staff.** — Familiarity with local conventions and systems varies, and it shows in prescription quality.

- **Errors are corrected but only the most serious ones get formally reviewed.**

IMPLEMENTATION PLAN

When	What
Week 1	Review a sample of recent prescriptions for legibility and completeness issues.
Week 2	Define or reinforce a specific second-check process for a named list of high-risk medications.
Week 3	Set up a simple error-tracking log, including near-misses, not only serious incidents.
Ongoing	Review tracked errors periodically for patterns, feeding lessons back to prescribing staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Prescription legibility and completeness check	Reviews a sample of recent prescriptions for legibility, completeness, and absence of ambiguity.
DOCUMENT	Second-check protocol review	Checks for a defined, followed second-check process specifically for high-risk medications.
ASK	Error-tracking interview	Asks pharmacy or nursing staff how a caught prescribing error is documented and whether it leads to any review.

SUPERVISOR TIPS

- **Ask to see the high-risk medication list specifically, not general policy.** — A facility that can't name its own high-risk medications likely doesn't have a real second-check process for them.
- **Ask how a near-miss, not just a serious error, gets handled.** — Near-miss handling reveals whether the system learns proactively or only reactively.
- **Ask who performs the second check, by name and role, not by job title assumption.** — In a facility with no clinical pharmacist role, this function is often performed by a physician or senior nurse —

confirm it is genuinely independent, not confirm it is a pharmacist specifically.

EVIDENCE BASE

WHO's Medication Without Harm Global Patient Safety Challenge (2017) identifies prescribing error as a leading, largely preventable contributor to medication-related harm worldwide, and does not specify which clinical role must perform the second check — only that one genuinely independent check occurs.

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4.11 The Surgical Safety Checklist Is Actually Used

NON-NEGOTIABLE

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

In plain terms: The WHO Surgical Safety Checklist is read aloud, by the whole team, at all three points — before anaesthesia, before the first cut, and before the patient leaves — for every operation.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The checklist works because it forces a pause and a conversation: is this the right patient, the right side, the right procedure? Are antibiotics given? Does everyone know their name and role? Its value is entirely in being spoken, together, in the moment. A checklist ticked by one person after the fact is compliance theatre. The original WHO study across eight countries showed complications fell by a third and deaths

by nearly half when the checklist was done properly. Hospitals that report 100% checklist completion and no change in outcomes are hospitals where the checklist is paperwork.

WHAT GOOD LOOKS LIKE

- The checklist is completed out loud, at all three checkpoints, with genuine team participation.
- Junior team members describe an active, expected role in the process, not passive presence.
- At least one documented instance exists of the checklist catching a real issue.

COMMON FAILURE MODES

- The checklist is completed silently or retrospectively, as paperwork.
- Only the most senior person present speaks during the checklist; others are passive.
- Nobody can recall the checklist ever catching anything, across its entire use history.

WORKED EXAMPLE

IN PRACTICE

A 200-bed hospital where theatre nurses completed the checklist form for each case.

BEFORE

The Coordinator observed four operations. The 'sign in' was a nurse asking the anaesthetist two questions. There was no 'time out' before incision. The 'sign out' was completed at the end of the list from memory. Forms were 100% complete. When asked, no team member could recall the checklist ever changing anything.

ACTION

The surgical director chaired a meeting where the checklist was explained as a team pause, not a form. For two weeks, the Coordinator sat in theatre and prompted the three stops until they became habit. Junior staff were explicitly told they were expected to speak. Any 'catch' — wrong side identified, allergy flagged, missing antibiotic — was recorded and read out at the weekly theatre meeting.

AFTER

The Monitor observed two operations: all three checkpoints performed aloud with full team participation. The catch log showed four events in six weeks, including one wrong-side marking corrected at time-out. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Sit in on three operations and watch — not the form, the team.
Is anyone speaking?
2. Count how many of the three checkpoints actually happen aloud.
3. Ask the most junior person in theatre what their role in the checklist is.
4. Start a 'catch log' — every time the checklist finds something, write it down and share it.

The most common mistake: Reporting 100% checklist completion based on signed forms — a signed form tells you nothing about whether anyone spoke.

SELF-ASSESSMENT QUESTIONS

1. Is the checklist completed out loud, as a team, before induction, before incision, and before the patient leaves theatre? — *All three checkpoints, spoken, not just the pre-induction one done and the rest skipped.*

Evidence: N/A — observed directly

2. Does every team member participate, not just the most senior person present? — *A checklist read by one person to a silent room misses its purpose — catching what any team member might notice.*

3. Is there evidence the checklist has actually changed a decision or caught an issue, not just been completed? — *A checklist that's never once caught anything real over time is worth questioning, not just checking for completion.*

Evidence: Any documented instance of checklist-caught issue

4. For any procedure involving laterality, multiple structures, or multiple levels, is the surgical site physically marked by the operating clinician before the patient enters theatre, and verified during the time-out? — *Explicit site marking and verification, not an*

assumption that confirming the procedure name alone rules out wrong-site error.

Evidence: Site-marking policy and observed compliance

COMMON REASONS FOR A PARTIAL ANSWER

- **The pre-induction check happens reliably; the other two checkpoints are inconsistent.** — The first checkpoint often becomes routine while the later ones, under time pressure to finish, get compressed or skipped.
- **The checklist is spoken but functions as a formality nobody expects to actually change anything.** — Ritual completion without genuine expectation of catching real issues loses most of the safety value.
- **Junior staff are present during the checklist but not genuinely invited to speak up.**

IMPLEMENTATION PLAN

When	What
Week 1	Directly observe several procedures to assess genuine checklist practice versus formality.
Week 2	Brief the whole surgical team on the expectation that all three checkpoints happen, spoken, every time.
Week 3	Explicitly invite junior staff participation as part of the checklist process, not just presence.
Ongoing	Track and share any instance where the checklist catches a genuine issue, reinforcing its real value to the team.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Live checklist observation	Directly observes checklist use during an actual procedure — or, where not possible, reviews the most recent documented instance in detail.
ASK	Team participation check	Asks a non-senior team member — not the lead surgeon — to describe their role in the checklist process.

Method	What	Detail
DOCUMENT	Checklist-catch history review	Reviews records for any documented instance where the checklist process caught a genuine issue before it caused harm.

SUPERVISOR TIPS

- **Observe live if at all possible, rather than relying on documentation alone.** — Paperwork can show 100% completion while live practice tells a very different story.
- **Watch specifically for the second and third checkpoints, not just the first.** — The pre-induction step is the most commonly performed genuinely; the later ones are where compliance most often erodes.

EVIDENCE BASE

[10] Haynes AB, Weiser TG, Berry WR, et al. "A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population." N Engl J Med. 2009;360(5):491-499 — the original eight-country study found surgical complications fell from 11.0% to 7.0%, and in-hospital death from 1.5% to 0.8%, following genuine checklist implementation.

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4.12 Anaesthesia Is Delivered Safely

NON-NEGOTIABLE

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

In plain terms: Anaesthesia follows written safety protocols with continuous monitoring appropriate to the patient and the level of anaesthesia — every time.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Anaesthesia is among the safest things a hospital does in well-resourced settings and among the most dangerous in poorly-resourced ones. The difference is almost entirely process: pre-anaesthetic assessment, the right monitoring (pulse oximetry at minimum, capnography for general anaesthesia), a trained person watching the patient continuously, and a recovery area with monitoring until the patient is safely awake. Deaths from anaesthesia are almost always failures of these basics, not exotic complications. The WHO-WFSA International Standards set the floor; the criterion asks whether the hospital meets it consistently, not just when the senior anaesthetist is on.

WHAT GOOD LOOKS LIKE

- Monitoring is continuous throughout every procedure, with no gaps at any stage.
- Equipment is regularly maintained and calibrated, with records to prove it.
- The anaesthesia team can describe a clear, specific escalation protocol confidently.

COMMON FAILURE MODES

- Monitoring gaps exist during the middle portion of longer procedures.
- Equipment maintenance records are incomplete or absent.
- The escalation protocol, if asked about, produces a vague or uncertain answer.

WORKED EXAMPLE

IN PRACTICE

A 120-bed hospital with two anaesthetists and three anaesthetic technicians covering emergency and elective lists.

BEFORE

Pre-anaesthetic assessment was done on the table for emergency cases. Pulse oximetry was available but capnography was on only one of three machines. Technicians sometimes ran cases alone when both anaesthetists were busy. Recovery had no dedicated monitored bed; patients returned to the ward directly. The

	Coordinator found two documented incidents of unrecognised hypoxia in the previous year.
ACTION	A written anaesthesia standard was adopted based on the WHO-WFSA minimum: assessment before every case, oximetry and capnography for all general anaesthetics, an anaesthetist or supervised technician present throughout, and a monitored recovery bay staffed until discharge criteria are met. Capnography was procured for the two remaining machines. A two-bed recovery bay was created next to theatre.
AFTER	The Monitor reviewed the standard, the equipment log, and 20 anaesthetic records: all showed pre-assessment, continuous monitoring, and recovery observations. Observed one case start to finish. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check each anaesthetic machine: is there pulse oximetry and capnography, and do they work?
2. Pull 20 anaesthetic records: is pre-assessment documented before every case?
3. Ask where patients go after surgery and who monitors them until they are awake.
4. Adopt the WHO-WFSA International Standards as your written protocol.

The most common mistake: Having good anaesthetic practice when the senior anaesthetist is present and different practice when they are not.

SELF-ASSESSMENT QUESTIONS

1. Is continuous monitoring maintained throughout the entire procedure, not just at induction and emergence? — *Gaps in monitoring during the middle of a long procedure are a real, documented risk pattern.*

Evidence: Monitoring record

2. Is the monitoring equipment appropriate to the level of anaesthesia and actually functioning, not just present? — *Equipment that's present but not properly calibrated or maintained provides false reassurance.*

Evidence: Equipment maintenance log

3. Is there a defined escalation protocol for anaesthesia-related complications? — *A protocol for the routine case is not the same as a protocol for when something goes wrong.*

Evidence: Escalation protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Monitoring is continuous for planned procedures but less consistent for emergency ones.** — Time pressure in emergency situations can compress steps that are reliably followed when there's more time.
- **Equipment exists and is used but calibration records are inconsistent.** — Equipment that works today doesn't prove it was properly calibrated when it mattered most.
- **An escalation protocol exists for common complications but not rarer, more serious ones.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent monitoring records for continuity gaps across a sample of procedures.
Week 2	Audit and update equipment calibration and maintenance records.
Week 3	Run a scenario-based briefing on escalation protocols, including less common complications.
Ongoing	Periodically test staff recall of escalation protocols through scenario discussion, not just document review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Monitoring continuity check	Observes a procedure, or reviews detailed monitoring records, to check for continuous coverage throughout, not just at key transition points.

Method	What	Detail
DOCUMENT	Equipment functionality check	Checks maintenance and calibration records for anaesthesia monitoring equipment.
ASK	Escalation protocol interview	Asks the anaesthesia team to describe the escalation protocol for a specific complication scenario.

SUPERVISOR TIPS

- **Ask about a specific, less common complication, not the routine case.** — General competence with common scenarios doesn't prove readiness for rarer, higher-stakes ones.
- **Check equipment records for gaps, not just presence of a maintenance schedule.** — A schedule that exists on paper and one that's actually followed are different things.

EVIDENCE BASE

[30] The WHO-WFSA International Standards for a Safe Practice of Anaesthesia establish continuous monitoring as a core, non-negotiable element of safe anaesthetic care across all resource settings.

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4.13 Surgical Site Infection Is Actively Prevented

NON-NEGOTIABLE

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

In plain terms: A specific, checkable bundle of surgical infection prevention steps is followed for every operation — not just a general intention to be careful.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Surgical site infections are the most common healthcare-associated infection in low- and middle-income countries, affecting up to one in five surgical patients. They double length of stay, multiply cost, and kill. Most are preventable with a small, well-evidenced bundle: correct antibiotic prophylaxis within 60 minutes before incision, no razor shaving, skin preparation with an alcohol-based agent, maintained normothermia, and glucose control. A bundle works because it is specific and checkable — each element is either done or not. ‘We take infection seriously’ is not a bundle.

WHAT GOOD LOOKS LIKE

- A specific, defined SSI prevention bundle is documented and consistently followed.
- The facility's own SSI rate is actively measured, tracked, and used to guide improvement.
- Compliance with the bundle is checked per procedure, with clear records.

COMMON FAILURE MODES

- No specific bundle exists beyond general infection control awareness.
- SSI rate is not measured or tracked at all.
- Compliance is assumed from training history, with no per-procedure verification.

WORKED EXAMPLE

IN PRACTICE

A 180-bed hospital with a surgical infection rate it did not measure.

BEFORE

Antibiotic prophylaxis was given ‘before surgery’ — sometimes on the ward two hours earlier, sometimes after incision. Patients were shaved with razors the night before. Skin prep varied by surgeon. Nobody knew the SSI rate. When the Coordinator reviewed 30 charts, timing of prophylaxis was documented in nine.

ACTION

A five-element SSI bundle was adopted and printed on the theatre checklist. Prophylaxis timing was moved to the anaesthetic room with the time recorded. Razors were removed from the wards; clippers were provided. Alcohol-chlorhexidine prep was standardised. A 30-day post-operative SSI surveillance call was introduced for all clean procedures.

AFTER

The Monitor reviewed 25 recent surgical records: all five bundle elements documented in 23. SSI surveillance showed a rate of 6%, down from an estimated 14% in the first month of measurement. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 20 surgical charts: is antibiotic prophylaxis timing recorded, and was it within 60 minutes of incision?
2. Check whether razors are still used for pre-operative hair removal.
3. Write your five-element bundle on one page and add it to the theatre checklist.
4. Start counting surgical infections — you cannot improve what you do not measure.

The most common mistake: Giving prophylactic antibiotics but not at the right time — an antibiotic given two hours early or after incision provides little protection.

SELF-ASSESSMENT QUESTIONS

1. Is a specific, defined SSI prevention bundle followed for every procedure, not general practice? — *“We’re careful about infection” is not the same as a specific, checkable bundle of practices.*
Evidence: SSI prevention bundle document
2. Is the facility’s own SSI rate actually measured and tracked? — *Improvement isn’t possible against a rate nobody is measuring.*
Evidence: SSI rate tracking data
3. Is bundle compliance checked per procedure, not assumed from general training? — *General training doesn’t guarantee the bundle was*

actually followed on any specific occasion.

Evidence: Per-procedure compliance record

COMMON REASONS FOR A PARTIAL ANSWER

- **A bundle exists and is generally known but compliance isn't checked per procedure.** — Awareness of a bundle and verified compliance with it on a specific occasion are different levels of assurance.
- **SSI rate is tracked but the data isn't reviewed or acted on regularly.** — Measurement without review provides no actual improvement pressure.
- **The bundle is followed well for high-risk procedures but less rigorously for routine ones.**

IMPLEMENTATION PLAN

When	What
Week 1	Document a specific SSI prevention bundle if one doesn't already exist in writing.
Week 2	Establish or verify SSI rate tracking, even in a simple form.
Week 3	Build per-procedure bundle compliance checking into the existing surgical checklist process.
Ongoing	Review SSI rate data on a fixed schedule and feed findings back to the surgical team.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Bundle definition and compliance review	Reviews the specific defined SSI prevention bundle and checks per-procedure compliance records.
DOCUMENT	SSI rate tracking check	Checks whether the facility measures and tracks its own SSI rate over time, and whether that data is used.
OBSERVE	Bundle practice observation	Observes a procedure, or reviews detailed records, for evidence the specific bundle elements were followed, not just general precautions taken.

SUPERVISOR TIPS

- **Ask for the SSI rate number directly.** — A facility that can't produce its own rate isn't actually tracking it, whatever staff believe.
- **Check compliance for a routine procedure, not just a high-risk one.** — Rigor often concentrates on perceived high-risk cases, leaving routine ones under-checked.

EVIDENCE BASE

[34] WHO's Global Guidelines for the Prevention of Surgical Site Infection (2016) establish an evidence-based bundle of specific practices shown to reduce SSI rates across diverse healthcare settings.

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4.14 The Lab Has Quality Control

NON-NEGOTIABLE

Internal quality control runs before results are released, every batch — a genuine check against known standards, not results released on the assumption equipment is working correctly.

In plain terms: The lab runs quality control checks before releasing any batch of results — and holds results if the control fails.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A laboratory result is only useful if it is right. Analysers drift, reagents degrade, calibration slips. Internal quality control — running a sample of known value alongside patient samples — is the only way to know that today's results are accurate. A lab that skips QC is guessing, and clinicians treat patients on guesses. The consequences are direct: a falsely normal potassium leads to an unrecognised arrhythmia; a

falsely high glucose leads to unnecessary insulin. QC must run every batch, results must be recorded, and — critically — when QC fails, patient results from that batch must be held, not released with a shrug.

WHAT GOOD LOOKS LIKE • Quality control precedes every batch release, verifiable through timestamped records. • A clear, followed protocol exists for QC failures. • QC records are retained and available for trend review over time.	COMMON FAILURE MODES • QC timing records show release happening before or without QC completion on some occasions. • Staff describe an uncertain or ad hoc response to QC failure. • QC records are checked once and not retained for later review.
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WORKED EXAMPLE

IN PRACTICE <i>A 150-bed hospital with an in-house lab running chemistry, haematology and microbiology.</i>	
BEFORE	QC material was available but run ‘when there was time’ — the log showed gaps of up to a week. When QC was out of range, technicians recalibrated and continued; the affected patient results were not reviewed. There was no written QC procedure and no rule about what to do when QC failed.
ACTION	A written QC procedure was introduced: control samples at defined levels run at the start of every batch, results plotted, and any out-of-range result triggers a hold on patient results from that run until resolved and documented. QC records became part of the daily supervisor sign-off. The lab joined an external quality assurance scheme.
AFTER	The Monitor reviewed three months of QC logs: continuous, with two documented failures, both followed by a hold and re-run. External QA reports showed acceptable performance. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Look at the QC log for the last month — are there gaps?
2. Ask what happens when a QC result is out of range. If the answer is 'we recalibrate and carry on,' that is the gap.
3. Write a one-page QC procedure including the hold rule.
4. Enrol in an external quality assurance scheme if you have not.

The most common mistake: Running QC but releasing patient results anyway when it fails — the QC then serves no purpose.

SELF-ASSESSMENT QUESTIONS

1. Does internal quality control run before every batch of results is released, without exception? — *“Usually” or “when there’s time” is not the same as a genuine non-negotiable step.*

Evidence: QC run records against release records

2. Is there a defined process for what happens when quality control fails? — *A QC failure needs a clear, followed response, not ad hoc decision-making in the moment.*

3. Are QC records retained and reviewable, not just checked and discarded? — *Retained records allow pattern detection over time that a single check can’t reveal.*

Evidence: QC record retention log

COMMON REASONS FOR A PARTIAL ANSWER

- **QC runs consistently for high-volume tests but is skipped under pressure for less common ones.** — Perceived low stakes for infrequent tests can quietly erode the same rigor applied elsewhere.
- **A QC failure protocol exists but staff have never actually had to use it.** — An untested protocol may look fine on paper and fail in practice under real pressure.
- **Records are retained but not actually reviewed for patterns over time.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit a sample of recent result releases against QC timing records for any gaps.

When	What
Week 2	Document or reinforce a clear, specific protocol for QC failures.
Week 3	Establish a retention system for QC records if one doesn't already exist.
Ongoing	Review retained QC data periodically for trends, not just individual pass/fail results.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	QC-to-release timing check	Compares quality control run timestamps against result release timestamps to verify QC genuinely precedes release, every time.
ASK	QC failure protocol interview	Asks lab staff to describe exactly what happens when a quality control check fails.
DOCUMENT	Record retention check	Checks whether QC records are retained over time and available for pattern review.

SUPERVISOR TIPS

- **Compare actual timestamps, don't accept a general assurance.** — "We always do QC first" is a claim; timestamped records are evidence.
- **Ask about a specific, less common test, not the highest-volume one.** — Rigor concentrated on high-volume tests can mask gaps elsewhere.

EVIDENCE BASE

Laboratory quality management frameworks, including CLSI and WHO laboratory quality standards, treat internal quality control as a non-negotiable precondition for result release, not an optional refinement.

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4.15 Critical Lab Values Reach the Doctor Fast

Critical results are reported through a faster, distinct pathway with confirmed receipt — not released into the same queue as routine results and left for someone to eventually notice.

In plain terms: When a lab result is dangerously abnormal, it reaches the responsible doctor fast through a separate pathway, and the lab confirms the doctor received it.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A potassium of 7.0 in the routine results queue is a death waiting to be discovered. Critical values — the results that require action within minutes to hours — must bypass the queue: a phone call, a page, a direct message, with the receiving clinician's name and the time recorded. 'Confirmed receipt' is the key phrase. A result faxed to a ward printer or posted to a system nobody is watching has not been communicated. Every hospital has a story of a critical result found the next morning. The standard exists to make that story impossible.

WHAT GOOD LOOKS LIKE

- A distinct, faster pathway exists and is used consistently for critical values.
- Receipt is confirmed by the receiving clinician every time, with records to prove it.
- A clear escalation protocol exists and is known for failed first-contact attempts.

COMMON FAILURE MODES

- Critical values are reported through the same queue as routine results.
- No confirmation of receipt exists beyond the result having been sent.
- Staff are uncertain what happens if the first contact attempt fails.

WORKED EXAMPLE

IN PRACTICE

A 130-bed hospital where all results were posted to the electronic record with a red flag for abnormal values.

BEFORE	Critical results were flagged red in the system, like all abnormalities. Nobody was notified. A patient with a haemoglobin of 4.2 was found at the next morning's ward round, 11 hours after the result. The lab had no list of which values were 'critical' and no phone protocol.
ACTION	The lab and medical director agreed a critical values list (18 tests with thresholds). For any result on the list, the technician phones the ward, speaks to a doctor or nurse, reads the result back, and records the name, time, and call outcome. If no one answers in five minutes, they escalate to the on-call registrar. The log is reviewed weekly.
AFTER	The Monitor reviewed the log: 40 critical calls in one month, all with a named recipient and time. Median time from result to call: 9 minutes. Asked a ward nurse what happens when the lab calls; she described the read-back. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask the lab: which values do you consider critical, and what do you do when you see one?
2. Check the last month for any critical result that was not acted on for hours.
3. Write a critical values list with thresholds — 15 to 20 tests is typical.
4. Introduce a phone protocol with read-back and a log.

The most common mistake: Relying on a red flag in the results system — a flag is only communication if someone is looking.

SELF-ASSESSMENT QUESTIONS

1. Is there a distinct, faster pathway for critical values, separate from routine result reporting? — *If critical values go into the same queue as everything else, speed depends on luck, not design.*

Evidence: Critical value pathway protocol

2. Is receipt of a critical value confirmed by the receiving clinician, not just assumed from transmission? — *A result sent is not the same as a result received and acknowledged by someone who can act on it.*

Evidence: Confirmed receipt log

3. Is there a defined escalation if the first attempt to reach a clinician fails? — *A single failed contact attempt shouldn't be where the process quietly stops.*

Evidence: Escalation protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **A distinct pathway exists during business hours but reverts to standard reporting overnight.** — Coverage gaps at specific times are a common, unstated exception to an otherwise good process.
- **Receipt confirmation happens for phone calls but not for other communication channels used.** — Different channels don't have consistent confirmation the same way.
- **An escalation protocol exists but the timeframe before escalating is vague.**

IMPLEMENTATION PLAN

When	What
Week 1	Map current critical value reporting against the actual, distinct pathway that should exist.
Week 2	Close any coverage gaps, particularly for out-of-hours periods.
Week 3	Define a specific timeframe and clear escalation trigger for failed first-contact attempts.
Ongoing	Review confirmed-receipt records periodically for any pattern of delay.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Pathway distinction check	Verifies a genuinely separate, faster pathway exists for critical values, distinct from routine reporting.
DOCUMENT	Confirmed receipt review	Reviews records for evidence of confirmed receipt by a clinician, not just transmission.
ASK	Escalation protocol interview	Asks lab staff what happens if the first attempt to reach a clinician about a critical value fails.

SUPERVISOR TIPS

- **Ask specifically about overnight and weekend coverage.** — A pathway that works well during business hours may not extend to when it's tested least often but needed just as much.
- **Ask for a specific example, not a description of the policy.** — A real recent example reveals whether the policy reflects practice.

EVIDENCE BASE

Critical value reporting protocols with confirmed receipt are a widely adopted patient safety standard precisely because delayed recognition of urgent results is a well-documented, preventable harm pathway.

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4.16 Specimens Are Correctly Identified

NON-NEGOTIABLE

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

In plain terms: Every specimen is labelled with two patient identifiers, checked at the bedside when collected and again in the lab before testing.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A mislabelled specimen is a result for the wrong patient. The consequences run from the trivial to the catastrophic: a wrong blood group leads to a fatal transfusion; a swapped biopsy leads to cancer treatment for a healthy person and no treatment for the sick one. Mislabelling happens in the seconds between drawing the sample and writing the label — a distraction, a second patient in the bay, a pre-printed label from the wrong chart. Two identifiers (name and date of birth, or name and hospital number) checked against the patient's wristband at the moment of collection is the only reliable barrier. The lab check is the second barrier for when the first fails.

WHAT GOOD LOOKS LIKE

- Two identifiers are consistently checked at both collection and pre-testing, independently.
- Staff describe a clear, confident stop-and-resolve process for any mismatch.
- Verification is genuine, not a formality performed without real attention.

COMMON FAILURE MODES

- Only one identifier is checked, or checking happens at only one of the two required points.
- Staff are uncertain what to do when identifiers don't match.
- Verification appears to be a rushed formality rather than genuine attention.

WORKED EXAMPLE

IN PRACTICE

A 170-bed hospital with a rejected-specimen rate the lab did not report.

BEFORE

Phlebotomists carried pre-printed labels for the whole ward and applied them at the nurses' station after the round. The lab rejected 3–4 specimens a day for labelling errors and quietly re-requested them. One transfusion crossmatch had been drawn on the wrong patient, caught by the lab because the blood group did not match a previous record.

ACTION	A bedside labelling rule was introduced: label in front of the patient, after checking name and date of birth against the wristband, with a second identifier written by hand if pre-printed. The lab began reporting rejected specimens by ward weekly. Wards with the highest rates received a 15-minute refresher.
AFTER	The Monitor observed four specimen collections, all labelled at the bedside with wristband check. Lab rejection rate had dropped from 4/day to under 1/day. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch three blood draws — where and when is the label applied?
2. Ask the lab how many specimens they reject for labelling and whether wards are told.
3. Make it a rule: label at the bedside, in front of the patient, after checking the wristband.
4. Report rejections by ward weekly.

The most common mistake: Labelling specimens at the nurses' station from a stack of pre-printed labels after the round.

SELF-ASSESSMENT QUESTIONS

1. Are two identifiers checked before specimen collection, not just one? — *A single identifier — a bed number, for instance — is not sufficient on its own.*

Evidence: Collection protocol

2. Is identity checked again before testing, independently of the collection-time check? — *A single check at collection doesn't catch an error introduced afterward, in transit or labelling.*

Evidence: Pre-testing verification record

3. Can staff describe what happens when identifiers don't match? — *A clear stop-and-resolve process, not proceeding anyway under time pressure, is essential.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Two-identifier checking happens reliably at collection but is skipped or assumed at pre-testing.** — The first check often becomes the well-established habit; the second, independent check is more easily eroded.
- **The process is followed for inpatients but less consistently for outpatients or urgent cases.** — Time pressure and unfamiliarity both erode consistency, and urgent cases combine both.
- **Staff know the process but occasionally skip it when “certain” they know the patient.**

IMPLEMENTATION PLAN

When	What
Week 1	Directly observe specimen collection across a sample of cases to check genuine two-identifier practice.
Week 2	Reinforce or establish an independent pre-testing verification step.
Week 3	Brief all relevant staff on the mismatch response process, with a clear, simple stop-and-resolve rule.
Ongoing	Spot-check practice periodically, particularly for urgent or outpatient specimens.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Collection-point identifier check	Observes specimen collection directly, or reviews protocol compliance records, for genuine two-identifier verification.
DOCUMENT	Pre-testing verification review	Checks for a documented, independent identity verification step immediately before testing, separate from collection.
ASK	Mismatch response interview	Asks staff to describe exactly what happens when identifiers don't match at either checkpoint.

SUPERVISOR TIPS

- **Watch for the second check specifically, not just the first.** — The pre-testing verification is where compliance most commonly erodes first.

- **Ask what happens with a familiar, frequently-seen patient.** — Familiarity-based shortcuts are the most common real-world failure mode for this exact requirement.

EVIDENCE BASE

[13] Two-identifier patient verification at specimen collection is a globally adopted patient safety standard specifically because single-identifier or single-check systems have repeatedly failed to catch misidentification in practice.

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4.17 Medication Storage Is Secure and Correct

NON-NEGOTIABLE

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

In plain terms: Medicines are stored at the right temperature, in a secure place, with access limited to authorised staff — and you can prove it.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Insulin left warm loses potency. Vaccines that freeze become useless. Controlled drugs in an unlocked cupboard disappear. Storage failures are invisible until the medicine does not work or goes missing — by which point the patient has been given an ineffective dose or the hospital has a diversion problem. The standard asks for specifics: refrigerators with continuous temperature logging and an alarm, locked storage for controlled drugs with a register, a list of who has keys, and evidence that all of this is checked. ‘The fridge has a thermometer’ is not temperature monitoring if no one reads it.

WHAT GOOD LOOKS LIKE

- Temperature-sensitive storage is consistently monitored, logged, and within range.
- Access is genuinely restricted to authorised staff, verifiable in practice.
- Routine checks happen on a defined schedule, catching drift early.

COMMON FAILURE MODES

- Temperature logs show gaps or unaddressed excursions outside the safe range.
- Storage access is effectively open to any staff member, regardless of authorisation.
- Checks happen only reactively, after a problem is suspected.

WORKED EXAMPLE

IN PRACTICE

A 110-bed hospital with medication refrigerators on each ward and a central pharmacy.

BEFORE

Ward fridges had thermometers but no log. The Coordinator found one at 12°C. Insulin and vaccines were stored inside. The controlled drug cupboard key was kept in an unlocked desk drawer 'for convenience.' The CD register had gaps and two unexplained discrepancies.

ACTION

Digital min-max thermometers with alarms were installed in every medicine fridge, with a twice-daily reading logged and signed. A written response for out-of-range readings was posted on each fridge. Controlled drug keys were assigned to the nurse in charge on a signed handover. The CD register was reconciled weekly by pharmacy and discrepancies escalated to the Director.

AFTER

The Monitor checked five fridges: all in range with continuous logs. Asked for the CD key; the nurse in charge produced it from her person. Register reconciled with no unexplained gaps in three months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Open every medicine fridge and read the temperature — is any outside 2–8°C?
2. Ask where the controlled drug key is right now.
3. Install min-max thermometers and start a twice-daily log.
4. Reconcile the CD register this week and explain every discrepancy.

The most common mistake: Having a thermometer in the fridge but no log — a reading nobody records might as well not exist.

SELF-ASSESSMENT QUESTIONS

1. Are temperature-sensitive medications stored within their required range, monitored and logged? — *A fridge that's "probably fine" is not the same as one with a monitored, logged temperature record.*

Evidence: Temperature monitoring log

2. Is access to medication storage restricted to authorised staff specifically, not generally available? — *General staff access, even with good intentions, undermines accountability and control.*

Evidence: Access control record

3. Are storage conditions checked routinely, not only when something seems wrong? — *Routine checking catches drift before it becomes a problem; reactive checking catches it after.*

COMMON REASONS FOR A PARTIAL ANSWER

- **Temperature is monitored but excursions aren't consistently followed up.** — Detection without response provides only partial protection.
- **Access restriction exists on paper but the physical lock or control isn't consistently enforced.** — A policy requiring restricted access means little if the door is routinely left open.
- **Routine checks happen for high-value medications but not consistently across all storage areas.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent temperature logs for gaps or unaddressed excursions.

When	What
Week 2	Verify and reinforce physical access control to medication storage areas.
Week 3	Establish a routine check schedule covering all storage areas, not only high-value ones.
Ongoing	Review temperature and access logs periodically for any drift or lapse.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Temperature log review	Reviews temperature monitoring logs for medication storage for consistency and any unaddressed excursions.
OBSERVE	Access control check	Checks whether medication storage access is genuinely restricted, not left open or accessible to unauthorised staff.
DOCUMENT	Routine check schedule review	Verifies storage conditions are checked on a routine schedule, not only reactively.

SUPERVISOR TIPS

- **Check the log for gaps, not just current readings.** — A current reading within range says nothing about what happened overnight or over a weekend.
- **Try accessing storage yourself, if appropriate, to test real restriction.** — A stated policy and an actually enforced physical control aren't always the same thing.

EVIDENCE BASE

[36] WHO's Medication Without Harm initiative identifies storage-related medication errors as a distinct, trackable category within the broader medication safety challenge, separate from prescribing and administration errors.

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

4.18 High-Alert Medications Get Extra Safeguards

NON-NEGOTIABLE

Insulin, anticoagulants, and concentrated electrolytes have an independent double-check before administration — a specific, mandatory second person, not the same clinician checking their own work twice.

In plain terms: Insulin, blood thinners, and concentrated electrolytes are double-checked by two people — independently, not one watching the other — before they are given.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

These drugs kill when the dose is wrong, and the dose is easy to get wrong. Ten units of insulin written as '10U' becomes 100 when the U is read as a zero. Potassium chloride concentrate given undiluted stops the heart. Heparin in the wrong strength causes fatal bleeding. An independent double-check — two people each calculating and checking without seeing the other's work, then comparing — catches the errors a single person's brain cannot see in its own work. It must be independent: one nurse reading out while the other nods catches nothing.

WHAT GOOD LOOKS LIKE

- A specific, named high-alert medication list exists and matches recognised categories.
- Double-checks are performed by a genuinely independent second person, every time.
- Every double-check is documented, with clear

COMMON FAILURE MODES

- No specific high-alert list exists beyond general caution.
- Double-checks are performed by the same person who prepared the medication.
- Double-checks are described as routine but no documentation exists to confirm they happened.

records available for review.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital where 'double-check' meant a second nurse initialled the chart.

BEFORE

The Coordinator observed insulin administration. Nurse A drew up the dose and asked Nurse B to 'check it.' B glanced at the syringe and initialled. Neither looked at the prescription. When asked, both said this was the double-check. An incident file contained a tenfold heparin overdose from the previous year that had been 'double-checked.'

ACTION

An independent check protocol was written: for the listed high-alert drugs, two staff each separately read the prescription, check the patient identity, calculate the dose, and check the drug and strength — then compare. Only if all match is it given. Both sign. A 20-minute session trained every nurse; ward managers observed compliance for a month.

AFTER

The Monitor observed three high-alert administrations: each with genuinely independent checks and comparison. Asked a nurse to explain the process; she described the separate calculation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch a high-alert drug being given. Did the second person independently calculate, or just look?
2. List your high-alert drugs — at minimum insulin, anticoagulants, concentrated electrolytes, opioids.
3. Write the independent check as steps: separately read, separately calculate, then compare.
4. Remove concentrated potassium chloride from ward stock entirely if you can.

The most common mistake: A ‘double-check’ where the second nurse watches the first and initials — that is one check with two signatures.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined, named list of high-alert medications requiring an independent double-check? — *A vague sense of “being extra careful” with certain medications is not the same as a specific, named list.*
Evidence: High-alert medication list

2. Is the double-check performed by a genuinely independent second person, not the same clinician? — *Self-verification doesn’t provide the independent perspective the safeguard is designed to add.*
Evidence: Double-check protocol and records

3. Is the double-check documented, not just assumed to have happened? — *An undocumented check leaves no way to verify it actually occurred as intended.*
Evidence: Documented double-check record

COMMON REASONS FOR A PARTIAL ANSWER

- **A high-alert list exists but is incomplete relative to recognised categories.** — An outdated or partial list leaves some genuinely high-risk medications without the extra safeguard.
- **Independent double-checking happens during busy hours less reliably than quiet ones.** — The safeguard is most likely to be skipped exactly when time pressure is highest — often also when error risk is highest.
- **Double-checks happen but documentation is inconsistent.**

IMPLEMENTATION PLAN

When	What
Week 1	Compare the current high-alert medication list against recognised categories and close any gaps.
Week 2	Reinforce the requirement for genuine independence in double-checking, not self-verification.
Week 3	Build documentation of the double-check directly into the administration record process.
Ongoing	Audit double-check documentation periodically, particularly during historically busier shifts.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	High-alert list verification	Checks for a specific, named list of high-alert medications and whether it matches recognised categories.
OBSERVE	Independent double-check observation	Observes or reviews records of the double-check process, checking specifically for genuine independence between the two checkers.
DOCUMENT	Documentation completeness check	Reviews administration records for high-alert medications to confirm the double-check is documented, not just assumed.

SUPERVISOR TIPS

- **Ask who performed the double-check on a specific recent administration.** — A specific name check reveals whether independence is genuine or assumed.
- **Check documentation completeness during a busy period specifically.** — Gaps concentrate under pressure — checking a calm period alone can miss this.

EVIDENCE BASE

[36] WHO's Medication Without Harm initiative specifically names high-alert medications — including insulin, anticoagulants, and concentrated electrolytes — as requiring targeted, additional safeguards beyond standard medication safety practice.

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

Tools and forms for this standard

Every criterion in Standard 4 maps to a free ASF tool. All 165 tools at france-asf.fr/tools. Key tools for this standard:

4.1 Consent 33.1 Informed Consent Form →	4.2 Credentials 26.1 Credential Verification →	4.3 Induction 26.3 Induction Checklist →
4.4 Staffing 33.6 Staffing Calculation →	4.5 Hand hygiene 2.1 Hand Hygiene Observation →	4.7 Waste 10.1 Waste Segregation →
4.8 Assessment 33.2 Clinical Assessment Form →	4.9 Care plan 33.3 Care Plan Template →	4.10 Prescribing 34.5 Prescription Chart →
4.11 Surgical safety 1.1 WHO Surgical Checklist →	4.14-4.16 Lab 24.1 Sample Labelling →	4.18 High-alert meds 4.2 High-Alert Double-Check →
4.19 Reconciliation 4.4 Medication Reconciliation →	4.20 Patient ID 5.1 Two Identifiers →	4.21 Falls 3.1 Fall Risk Screening →
4.23 Restraint 34.7 Restraint Order Form →	4.24 Nutrition 34.4 MUST Nutrition Screen →	4.25 Deterioration 34.1 NEWS2 Chart →
4.26 Sepsis 34.2 Sepsis Six Bundle →	4.27 Pressure injury 12.1 Braden Scale →	4.28 VTE 34.3 VTE Risk Assessment →
4.29 Blood 21.1 Transfusion Bedside Check →	4.30 Handoffs 5.3 SBAR Card →	4.31 Opioids 34.6 Opioid Count Sheet →

4.32 Pain

[33.4 Pain](#)

[Assessment](#)

[Scale](#) →

4.35 Advance directive

[33.5 Advance](#)

[Directive Record](#)

→

ALL 165 TOOLS →

← **Hospital Standards — all
standards**

**Self-assess against these
criteria** →

← **Standard 3 —
Environment & Shared
Spaces**

**Standard 5 — Safety &
Emergency Preparedness** →

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ASF STANDARDS · HOSPITAL · STANDARD 5

Standard 5 — Safety & Emergency Preparedness

6 criteria · 6 non-negotiable · 0 core · Version 3.0

CRITERIA IN THIS STANDARD

5.1 — Triage Actually Sorts Patients by Urgency

5.2 — Resuscitation Equipment Is Ready Right Now

5.3 — There's a Real Disaster Response Plan

5.4 — Fire Safety Is Real, Not Theoretical

5.5 — Workplace Violence Is Prevented, Not Just Responded To

5.6 — Internal Emergency Alerts Are Clear, Consistent, and Trained

5.1 Triage Actually Sorts Patients by Urgency

NON-NEGOTIABLE

A structured triage system using a validated, internationally recognised urgency scale — such as the Manchester Triage System, the Canadian Triage and Acuity Scale, or an equivalent validated tool — prioritises patients by clinical urgency, used consistently for every arriving patient, not applied selectively based on how busy the department is.

In plain terms: Emergency patients are sorted by how urgent they are using a recognised triage scale — not seen in arrival order or by who complains loudest.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

In any emergency department, the sickest patient is not the one at the front of the queue. Triage puts them there. Without a validated scale — Manchester, CTAS, ESI — triage becomes the receptionist's guess, and the patient with chest pain who looks fine sits behind the one with a loud cough. A validated scale gives every patient a category and every category a maximum wait, so the person with a stroke is seen in minutes, not hours. It also protects staff: a documented triage category is evidence of a defensible decision.

WHAT GOOD LOOKS LIKE

- A validated, named triage scale is used consistently by every staff member performing triage.
- Urgency categories are documented for every patient with their implied maximum wait time.
- Staff can name the scale and describe their reasoning for a real recent categorisation confidently.

COMMON FAILURE MODES

- Triage relies on individual clinical judgement without reference to any named, validated scale.
- Different staff members apply visibly different standards for the same presenting complaint.
- Urgency categories, if assigned, aren't documented or linked to any specific wait time commitment.

WORKED EXAMPLE

IN PRACTICE

A 180-bed hospital whose emergency department saw patients in order of arrival.

BEFORE

Patients registered at a desk and waited. A nurse 'kept an eye' on the waiting room. The Coordinator reviewed the previous year's incidents: two deaths in the waiting room, both

	patients who had waited over an hour with unrecognised critical illness. There was no triage category on any record.
ACTION	The Manchester Triage System was adopted. A triage nurse assessed every patient within 10 minutes of arrival, assigned a category (1–5), and recorded it with the target time. Category 1 and 2 patients went directly to the resuscitation area. A board showed the waiting room by category. Triage nurses completed a two-day course.
AFTER	The Monitor observed triage for an hour: every patient categorised within 10 minutes. Reviewed 50 records: category and time-to-treatment recorded, category 2 patients seen within 15 minutes in 92%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask how patients are prioritised in your emergency department.
If the answer involves 'judgment' with no scale, that is the gap.
2. Choose one validated scale — Manchester, CTAS or ESI — and get training.
3. Put a triage nurse at the door assessing every patient within 10 minutes.
4. Record the category and time on every record.

The most common mistake: Having a nurse 'watch the waiting room' and calling that triage — triage is a structured assessment, not vigilance.

SELF-ASSESSMENT QUESTIONS

1. Is a validated, internationally recognised triage scale used, not an informal or home-grown urgency judgement? — *A named, validated tool — Manchester Triage System or equivalent — not individual staff discretion alone.*

Evidence: Triage scale documentation and completed sample

2. Does every triage nurse or staff member use the same scale consistently, not a personal variation of it? — *Consistency across staff*

is what makes the scale meaningful as a system, not just a suggestion.

Evidence: Staff training record on the specific scale used

3. Is the assigned urgency category documented for every patient, with the maximum wait time it implies? — *A category without a documented, implied wait time doesn't translate into an actual commitment to the patient.*

Evidence: Documented urgency category and wait time sample

COMMON REASONS FOR A PARTIAL ANSWER

- **A validated scale is used by senior triage nurses but newer or covering staff sometimes default to informal judgement.** — Formal training on a specific scale needs to reach everyone who performs triage, not just the most experienced staff.
- **The scale is used correctly for common presentations but less reliably for less familiar or atypical ones.** — Validated scales are designed for exactly this consistency, but familiarity with common cases can make staff over-confident with unusual ones.
- **Categorisation happens but isn't consistently re-checked if a patient's condition changes while waiting.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm which triage approach is currently used and whether it is a validated, named scale.
Week 2	Adopt a validated scale if none is currently in use, and train all staff who perform triage.
Week 3	Establish consistent documentation of assigned urgency category and implied wait time for every patient.
Ongoing	Periodically observe triage practice across different staff members to confirm consistent application.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Scale validation review	Reviews which triage scale is in use and confirms it is a validated, named system, not an informal internal variation.

Method	What	Detail
OBSERVE	Live triage consistency check	Observes triage being performed by different staff members, checking for consistent application of the same scale.
ASK	Staff scale familiarity interview	Asks triage staff to name the scale in use and describe how a specific recent case was categorised.

SUPERVISOR TIPS

- **Ask staff to name the specific scale, not just describe general urgency sorting.** — A facility genuinely using a validated scale can name it immediately; one relying on informal judgement usually cannot.
- **Observe triage by more than one staff member if possible.** — Consistency across individuals is the real test of whether a scale is genuinely standardising practice.

EVIDENCE BASE

[16] The Manchester Triage System, the Canadian Triage and Acuity Scale, the Australasian Triage Scale, and the Emergency Severity Index are the four most internationally established validated triage scales, each using a defined five-level urgency classification with documented reliability and predictive validity for patient outcomes.

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5.2 Resuscitation Equipment Is Ready Right Now

NON-NEGOTIABLE

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

In plain terms: The resuscitation trolley is checked every shift, fully stocked and working, and the staff who will use it are up to date on their life support training.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

When a patient arrests, the trolley either has what is needed or it does not. A flat defibrillator battery, an empty adrenaline slot, a laryngoscope with a dead bulb — each is discovered at the one moment it cannot be fixed. Checking every shift, with a signed checklist, is the only defence. The second half is competency: a trolley is only useful in trained hands. Basic life support certification lapses; a nurse who trained three years ago and has not practised since will freeze. 'Genuinely current' means the certificate is in date and the person has practised recently.

WHAT GOOD LOOKS LIKE

- Shift checks are documented consistently, every shift, with no gaps.
- Equipment is fully stocked and functional at the point of assessment.
- All relevant staff hold current, unexpired life support certification.

COMMON FAILURE MODES

- Shift check logs show gaps or inconsistent completion.
- Equipment found during assessment has missing or expired components.
- One or more staff members have lapsed certification without a tracked renewal plan.

WORKED EXAMPLE

IN PRACTICE

A 130-bed hospital with resuscitation trolleys on each ward.

BEFORE

Trolleys were checked 'weekly' by whoever remembered. The Coordinator opened four: one defibrillator had a flat battery; one adrenaline box was empty; one had expired drugs. The BLS training record showed 40% of nursing staff with expired certificates. Nobody had practised a mock arrest in two years.

ACTION	A per-shift trolley checklist was introduced, sealed with a numbered tag; the incoming nurse checks the seal and signs. Contents were standardised across all trolleys. BLS training was scheduled for all clinical staff on a two-year cycle with a tracking spreadsheet. Quarterly mock arrests were run on rotating wards.
AFTER	The Monitor opened three trolleys unannounced: sealed, fully stocked, checklist signed for every shift. BLS compliance 96%. Reviewed two mock arrest debriefs. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Open every resuscitation trolley today and check: defibrillator charged? Adrenaline present? Anything expired?
2. Pull the BLS training records — how many are expired?
3. Introduce a per-shift check with a seal and signature.
4. Schedule a mock arrest on one ward this month.

The most common mistake: Checking the trolley weekly — an arrest on Thursday does not care that the trolley was checked on Monday.

SELF-ASSESSMENT QUESTIONS

1. Is resuscitation equipment checked every shift, with a documented record? — *Not checked "regularly" — checked every single shift, verifiably.*

Evidence: Shift check log

2. Is all equipment found fully stocked and functional at each check, with gaps immediately addressed? — *A check that finds gaps but doesn't trigger immediate resupply provides only partial protection.*

Evidence: Gap resolution record

3. Are all relevant staff current on life support certification, not overdue? — *A lapsed certification discovered only during an emergency is a preventable failure.*

Evidence: Certification tracking record

COMMON REASONS FOR A PARTIAL ANSWER

- **Checks happen consistently during day shifts but less reliably overnight.** — Staffing levels and supervision often differ by shift, and routine tasks can erode accordingly.
- **Equipment is checked but gaps found aren't always resolved before the next shift.** — Detection without immediate resolution leaves a real gap in coverage.
- **Certification tracking exists but renewal reminders aren't proactive.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit shift check log completeness across all shifts, including overnight.
Week 2	Establish an immediate resolution process for any gap found during a check.
Week 3	Build a proactive certification renewal tracking and reminder system.
Ongoing	Spot-check equipment readiness and certification currency periodically, unannounced.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Shift check log review	Reviews shift check logs for consistency and completeness across a representative time period.
OBSERVE	Live equipment check	Directly inspects resuscitation equipment for stock completeness and functionality at the time of assessment.
DOCUMENT	Certification currency check	Reviews staff certification records for any lapsed or soon-to-lapse life support credentials.

SUPERVISOR TIPS

- **Check overnight and weekend logs specifically, not just weekday daytime records.** — Coverage gaps concentrate in less-supervised shifts.
- **Physically inspect equipment yourself rather than relying on the log alone.** — A completed log entry and genuinely current

equipment aren't always the same thing.

EVIDENCE BASE

Resuscitation readiness protocols, including scheduled equipment checks and current life-support certification, are foundational elements of resuscitation system quality frameworks across international emergency care guidance.

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5.3 There's a Real Disaster Response Plan

NON-NEGOTIABLE

A mass casualty and disaster response plan exists and has actually been practised through a drill, not written once and filed without ever being tested.

In plain terms: A mass casualty and disaster plan exists, staff know their roles, and it has been tested in a real drill — not just written and filed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A bus crash brings 30 casualties to your door in 20 minutes. A fire in the next building sends smoke through your wards. An earthquake cuts power and water. In each case, the plan either exists in staff's heads and hands or it does not exist at all. A written plan nobody has practised is a document, not a capability. Drills reveal what the plan missed: the call-in list has wrong numbers, the triage area is too small, nobody knows who is in charge. Better to find that on a Tuesday afternoon drill than at 2am with real casualties.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- A specific, detailed disaster response plan exists and has been practised through a real drill.
- Staff can describe their specific role in the plan confidently.
- Drill outcomes are documented and have led to real plan improvements.

- A plan exists only as a document, never practised through any drill.
- Staff asked about their role in a disaster scenario have no clear answer.
- No evidence exists that drill lessons, if any drill occurred, changed the plan at all.

WORKED EXAMPLE

IN PRACTICE

A 200-bed hospital that is the only trauma centre in a region prone to road accidents.

BEFORE

A 40-page disaster plan existed, written in 2018. Staff had never seen it. The call-in list had 30% wrong numbers. There was no designated incident commander role, no triage area plan, no blood bank surge arrangement. The last drill was 'before the current director.'

ACTION

The plan was rewritten as a 10-page action card set: one card per role (commander, triage, ward, blood bank, communications). The call-in list was verified. A tabletop exercise was run with department heads, then a live drill with 15 volunteer 'casualties.' The drill debrief found six gaps, each assigned an owner.

AFTER

The Monitor reviewed the plan, action cards, verified call-in list, and drill report with follow-up actions closed. Asked three staff their disaster role; all answered. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find your disaster plan and check the date. If staff have not seen it, it does not exist.
2. Phone ten numbers on the call-in list — how many are right?

3. Rewrite it as one action card per role, one page each.
4. Run a tabletop exercise with department heads this quarter.

The most common mistake: Having a comprehensive written plan that has never been tested — the untested plan is always wrong.

SELF-ASSESSMENT QUESTIONS

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

Evidence: Disaster response plan document

2. Has the plan actually been practised through a drill, not just written and filed? — *An unrehearsed plan's real-world gaps are unknown until an actual disaster reveals them.*

Evidence: Drill record, including date and participants

3. Were lessons from the drill documented and used to update the plan? — *A drill that doesn't feed back into plan improvement misses much of its value.*

Evidence: Post-drill review and plan revision record

COMMON REASONS FOR A PARTIAL ANSWER

- **A drill was run once, years ago, with no repeat since.** — Staff turnover and plan changes mean a single historical drill doesn't reflect current readiness.
- **The plan is detailed for the facility's own response but doesn't address coordination with external emergency services.** — Real disasters typically require coordination this kind of plan sometimes overlooks.
- **A drill happened but was announced well in advance, testing preparation rather than genuine readiness.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the current disaster plan for specificity and last drill date.
Week 2	Schedule and run a drill if none has occurred recently.

When	What
Week 3	Conduct a structured post-drill review and document specific plan improvements.
Ongoing	Repeat drills on a fixed schedule, varying scenarios and announcement timing.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Plan and drill record review	Reviews the disaster response plan document and checks for evidence of an actual, dated drill.
ASK	Staff role-awareness interview	Asks a staff member their specific role in the disaster plan, testing genuine familiarity versus general awareness a plan exists.
DOCUMENT	Post-drill improvement check	Checks whether any post-drill review led to documented changes in the plan.

SUPERVISOR TIPS

- **Ask for the drill date and participant list, not a general assurance drills happen.** — Specific, dated evidence is the only real proof of practice.
- **Ask a random staff member their specific role, not a senior manager who wrote the plan.** — Genuine, distributed familiarity is the real test, not authorship-level knowledge.

EVIDENCE BASE

Disaster preparedness frameworks consistently identify drill practice, not plan documentation alone, as the determining factor in real-world response effectiveness during mass casualty events.

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5.4 Fire Safety Is Real, Not Theoretical

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

In plain terms: Fire extinguishers, alarms, and exits are tested on schedule, and an evacuation drill has actually been run with real staff participation.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Hospital fires kill patients who cannot walk. Every year, fires in hospitals with untested alarms, blocked exits, and staff who have never practised evacuation cause deaths that a functioning system would have prevented. Equipment testing is the easy part — a contractor does it. The hard part is the drill: moving bedridden patients, horizontal evacuation to the next fire compartment, knowing who counts heads. Staff who have done it once, even in a drill, act; staff who have only read the policy freeze.

WHAT GOOD LOOKS LIKE

- Fire safety equipment is tested on a consistent, documented schedule.
- A real evacuation drill has been run, with genuine staff and area participation.
- Evacuation routes are verified clear at the time of assessment.

COMMON FAILURE MODES

- Equipment testing records show gaps or don't exist.
- No evidence of an actual physical evacuation drill, only a written plan.
- Evacuation routes are found obstructed by stored equipment or furniture.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital in a four-storey building.

BEFORE	Extinguishers had inspection tags dated 18 months earlier. Two fire exits on the third floor were locked with a chain 'to prevent theft.' The alarm had not been tested in a year. No evacuation drill had been run since the building opened. Staff could not say how they would move ICU patients.
ACTION	A fire safety contract was renewed with monthly alarm tests and annual extinguisher service. Chains were removed; exits fitted with alarmed push bars. A horizontal evacuation plan was written per floor. A drill was run on the third floor with 10 volunteer 'patients,' including two on beds. The debrief identified that the fire doors did not close automatically; this was fixed.
AFTER	The Monitor found all exits clear and alarmed, extinguishers in date, alarm test log current. Reviewed the drill report. Asked an ICU nurse how she would evacuate; she described horizontal evacuation to the adjacent compartment. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk every fire exit today and try to open it. Any locked or blocked exit is an emergency.
2. Check extinguisher tags — are they in date?
3. Find out when the alarm was last tested.
4. Schedule a drill on one floor this month, with beds.

The most common mistake: Locking fire exits to stop theft or unauthorised access — this has killed patients in hospital fires worldwide.

SELF-ASSESSMENT QUESTIONS

1. Is fire safety equipment tested on a defined schedule, with records kept? — *Extinguishers, alarms, and sprinkler systems specifically, not a general assumption of functionality.*
Evidence: Fire equipment testing log

2. Has an evacuation drill actually been run, with real staff and patient-area participation? — *A tabletop discussion of the evacuation plan is not the same as a physical drill.*

Evidence: Drill record, date and scope

3. Are evacuation routes kept genuinely clear, not obstructed in practice? — *A route that's clear on paper but blocked by stored equipment fails when it matters.*

Evidence: Route clearance check

COMMON REASONS FOR A PARTIAL ANSWER

- **Equipment testing happens for alarms but less consistently for extinguishers or sprinkler systems.** — Different systems can develop different, uneven testing discipline over time.
- **A drill was run in one part of the facility but not extended to all areas.** — Partial drilling tests partial readiness, leaving genuine gaps in areas never included.
- **Evacuation routes are clear during the day but accumulate obstruction over time between checks.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit fire safety equipment testing records for consistency across all system types.
Week 2	Schedule and run a genuine evacuation drill if none has occurred recently, covering all areas.
Week 3	Establish a routine evacuation route clearance check, not just a one-time verification.
Ongoing	Repeat drills on a fixed schedule and monitor route clearance routinely.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Equipment testing record review	Reviews fire safety equipment testing records for schedule consistency.
DOCUMENT	Drill record check	Checks for a specific, dated evacuation drill record, including scope and participation.

Method	What	Detail
OBSERVE	Evacuation route check	Physically checks that marked evacuation routes are genuinely clear and unobstructed.

SUPERVISOR TIPS

- **Ask for the drill date and which areas were included, not a general statement drills occur.** — Partial drilling is a common, specific gap worth checking directly.
- **Walk the evacuation routes yourself.** — Obstruction accumulates gradually and may not be visible from records alone.

EVIDENCE BASE

Fire safety and evacuation drill practice are established requirements in healthcare facility safety frameworks precisely because untested procedures reliably fail to translate into effective real-world response.

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

5.5 Workplace Violence Is Prevented, Not Just Responded To

NON-NEGOTIABLE

A specific workplace violence prevention policy covers violence from patients, visitors, and staff-on-staff, with real preventive measures in place — not a policy that only describes what happens after an incident occurs.

In plain terms: The hospital prevents violence — from patients, visitors, or staff against staff — with real measures, not just a policy about what to do after it happens.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Healthcare workers face more workplace violence than any other profession except police. Verbal abuse is daily; physical assault is common; staff leave because of it. Violence also harms patients: a nurse who has been assaulted is a nurse who withdraws. Prevention means identifying where it happens (emergency departments, psychiatric units, night shifts), reducing triggers (long waits, poor communication, alcohol), designing safe spaces (escape routes, panic buttons, visible security), and training staff in de-escalation. A policy that says 'report incidents to your manager' is a response, not prevention.

WHAT GOOD LOOKS LIKE

- A written policy explicitly covers both patient/visitor violence and staff-on-staff violence.
- The policy was developed with genuine staff consultation.
- Real preventive measures are visibly in place, not only a response plan.

COMMON FAILURE MODES

- The policy addresses only patient/visitor violence, silent on staff-on-staff incidents, or vice versa.
- The policy was issued without any staff consultation.
- Only a post-incident response plan exists, with no genuine preventive measures.

WORKED EXAMPLE

IN PRACTICE

A 170-bed hospital with an emergency department that sees intoxicated patients nightly.

BEFORE

Staff reported verbal abuse daily and two physical assaults in the past year, one causing injury. The incident log showed 30 violence reports; staff said most went unreported. There was no security presence after 10pm, no panic button, no de-escalation training. The policy said to 'call the police if necessary.'

ACTION

A workplace violence risk assessment identified ED nights and the psychiatric ward as highest risk. Security was staffed until 6am in ED. Panic buttons were installed at triage and reception. All

ED and psychiatric staff completed a half-day de-escalation course. Waiting-time communication was improved (see 2.5). A zero-tolerance sign was posted. Every incident was reviewed monthly.

AFTER

The Monitor reviewed the risk assessment, training records, and incident trend: reports up (better reporting) but assaults down from 2 to 0. Interviewed three ED nurses who described the panic button and de-escalation techniques. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five frontline staff when they were last verbally abused or threatened. The answer will surprise you.
2. Map where and when violence happens — which unit, which shift.
3. Install panic buttons where it happens most.
4. Book de-escalation training for the highest-risk units.

The most common mistake: Treating violence as a policing problem rather than a prevention problem — by the time you call the police, the harm is done.

SELF-ASSESSMENT QUESTIONS

1. Is there a written workplace violence policy covering violence from patients and visitors, and separately, staff-on-staff violence? — *Both categories explicitly, not just one assumed to cover the other.*

Evidence: Workplace violence policy document

2. Was the policy developed in consultation with staff, not written and issued without their input? — *Genuine consultation, since staff experience is what makes a prevention policy actually relevant.*

Evidence: Consultation record

3. Are real preventive measures in place — not only a response plan for after an incident occurs? — *Prevention, not just reaction — physical measures, staffing considerations, early warning signs training.*

Evidence: Preventive measures documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **The policy covers patient and visitor violence well but staff-on-staff violence is addressed only vaguely.** — Workplace violence prevention often develops with more attention to external threats than internal ones.
- **Consultation happened once at the policy's creation but hasn't been revisited as conditions changed.** — A policy set once without periodic review may not reflect current real risks or staff experience.
- **Preventive measures exist for physical security but not for early recognition and de-escalation training.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the current policy for coverage of both violence categories and evidence of staff consultation.
Week 2	Consult staff directly if the policy was not originally developed with their input.
Week 3	Establish specific preventive measures, including de-escalation training, not only physical security or response planning.
Ongoing	Revisit the policy and preventive measures periodically as conditions and staff feedback evolve.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Policy scope review	Reviews the workplace violence policy for coverage of both patient/visitor and staff-on-staff violence.
DOCUMENT	Consultation record check	Checks for evidence the policy was developed with genuine staff consultation.
OBSERVE	Preventive measures check	Checks for real, implemented preventive measures, not only a documented post-incident response plan.

SUPERVISOR TIPS

- **Ask staff directly whether they were consulted on the policy.** — Staff-reported consultation experience is more reliable than a policy document's stated process.
- **Ask about staff-on-staff violence specifically, not just patient and visitor incidents.** — This category is more commonly under-addressed in practice.

EVIDENCE BASE

[3] Established hospital accreditation frameworks, recognized in various forms across many countries, define workplace violence prevention as a required organizational practice, including violence from patients, visitors, and co-workers, requiring a written policy developed in consultation with staff.

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5.6 Internal Emergency Alerts Are Clear, Consistent, and Trained

NON-NEGOTIABLE

The facility has a clearly defined, documented internal emergency alert system — whether colour-coded or plain-language — covering the significant emergency types relevant to this facility, with every staff member trained and able to respond correctly, not assuming staff will infer meaning from context.

In plain terms: The hospital has a clear, written system for internal emergency alerts — fire, cardiac arrest, security threat, disaster — and every staff member knows what each alert means and what to do.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

'Code Blue' means cardiac arrest in one hospital and fire in another. A new nurse who trained elsewhere hears the alert and runs the wrong way. A cleaner hears 'Code Orange' and has no idea whether to evacuate or stay. Alerts only work if everyone knows them. The standard does not require colour codes — plain language ('Cardiac arrest, Ward 3') is often better. It requires that the alert types are defined, that everyone including support staff has been told what they mean, and that the alerts are tested. An emergency alert system that only clinical staff understand fails the moment a porter is the first to see the fire.

WHAT GOOD LOOKS LIKE

- A clear, documented internal alert system exists, whether colour-coded or plain-language.
- All staff categories, including temporary and agency staff, are trained on this specific system.
- Staff can correctly state the required response for each alert type used.

COMMON FAILURE MODES

- No documented system exists; staff are expected to infer meaning from context or prior experience elsewhere.
- Training reaches long-term staff but not temporary, agency, or newly hired staff.
- Staff recognise that an alert occurred but cannot state the correct required response.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital with an overhead PA system and an informal set of codes.

BEFORE

Codes were 'known' but not written. Staff gave four different meanings for 'Code Red.' The PA was inaudible in the basement and outpatients. New staff were not told the codes at induction. Cleaning and kitchen staff had never been told any codes.

ACTION

Five plain-language alerts were defined: 'Fire alert,' 'Cardiac arrest,' 'Security alert,' 'Disaster alert,' and 'Missing patient,' each with the location

appended. A one-page card was posted in every room and given to every staff member including contractors. The PA was extended to the basement and outpatients. Alerts were added to induction and tested monthly.

AFTER

The Monitor asked eight staff — including a cleaner and a kitchen assistant — what 'Fire alert, Ward 2' means and what they do. All answered correctly. PA audible in all areas. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five staff from different roles what 'Code Red' means.
Compare the answers.
2. Write down your alert types and what each means — five is usually enough.
3. Use plain language if colour codes cause confusion.
4. Post the list in every room and add it to induction for everyone, including contractors.

The most common mistake: Assuming clinical staff know the codes and forgetting the porter, cleaner, and security guard who may be first on the scene.

SELF-ASSESSMENT QUESTIONS

1. Does the facility have a clearly documented internal emergency alert system, whether colour-coded or plain-language? — *A specific, written system — not an assumption that staff will understand codes from general experience elsewhere.*

Evidence: Internal emergency alert system document

2. Are all staff, including new hires and temporary or agency staff, trained on this specific facility's system? — *Facility-specific training, not reliance on what a code meant at a previous workplace.*

Evidence: Training record covering all staff categories

3. Can staff correctly state what happens for each alert type used at this facility, not just recognise that an alert occurred? —

Understanding the required response, not just recognising that something

is happening.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The system is well understood by clinical staff but not by support, administrative, or facilities staff who may also need to respond.** — Emergency response often depends on more than just clinical staff, and gaps in non-clinical understanding create real coordination risk.
- **Training happens at induction but is never refreshed, and understanding fades over time.** — A one-time training without periodic reinforcement doesn't guarantee lasting recall under real pressure.
- **The system is clear for common alerts like cardiac arrest but less clear for less frequent ones like an infant abduction or bomb threat.**

IMPLEMENTATION PLAN

When	What
Week 1	Document the facility's current internal emergency alert system clearly, whether colour-coded or plain-language.
Week 2	Extend training to cover all staff categories, including temporary and agency staff specifically.
Week 3	Consider whether a plain-language approach would reduce confusion, particularly for facilities with high staff turnover or many temporary staff.
Ongoing	Refresh training periodically, with particular attention to less frequently used alert types.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Alert system documentation review	Reviews the facility's documented internal emergency alert system for clarity and completeness across relevant emergency types.

Method	What	Detail
ASK	Staff response interview	Asks staff, including newer or temporary staff, what a specific alert means and what their required response is.
DOCUMENT	Training coverage check	Reviews training records to confirm coverage extends to temporary, agency, and newly hired staff, not only long-term permanent staff.

SUPERVISOR TIPS

- **Ask a temporary or newer staff member specifically, not a long-term employee.** — This is where genuine gaps in facility-specific understanding are most likely to surface.
- **Ask about a less common alert type, not just the most familiar one.** — Understanding of rare but critical alerts often lags behind common ones like a cardiac arrest code.

EVIDENCE BASE

[5] Multiple national safety bodies now recommend plain-language emergency alerts specifically because colour-code meanings have been shown to vary significantly and dangerously between hospitals, regions, and countries.

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Standard 6 — Aftercare & Follow-up →

ASF STANDARDS · HOSPITAL · STANDARD 6

Standard 6 — Aftercare & Follow-up

3 criteria · 3 non-negotiable · 0 core · Version 3.0

CRITERIA IN THIS STANDARD

- 6.1 — Every Discharged Patient Gets a Real Aftercare Plan
- 6.2 — A Real Mechanism Checks on the Patient After They Leave
- 6.3 — Patients Can Complain After Leaving, and Complaints Are Actually Read

6.1 Every Discharged Patient Gets a Real Aftercare Plan

NON-NEGOTIABLE

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

In plain terms: Every patient leaving hospital gets a written aftercare plan and can tell you, in their own words, what to do and when to worry.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Discharge is where hospitals lose patients. The handover from ward to home is the least controlled transition in healthcare: the patient is tired, the family is anxious, the nurse is busy, and a sheet of paper is handed

over on the way out. Readmission within 30 days is often a discharge failure: a medication misunderstood, a warning sign not recognised, a follow-up not attended. A real aftercare plan is explained, not just given — the patient repeats back what they will do, when to take what, and what symptoms mean 'come back now.' Teach-back at discharge cuts readmissions.

WHAT GOOD LOOKS LIKE

- Every patient receives a documented, patient-specific aftercare plan.
- Patients contacted after discharge can accurately describe their own plan.
- Plans consistently cover medication, warning signs, and who to contact for concerns.

COMMON FAILURE MODES

- Discharge information is a generic printed sheet, identical regardless of the patient's actual situation.
- Patients contacted after discharge cannot describe what they were told.
- Plans are missing key elements like warning signs or contact information for concerns.

WORKED EXAMPLE

IN PRACTICE

A 160-bed hospital with a 30-day readmission rate of 14%.

BEFORE

Discharge was a printed summary handed over by the ward clerk. The Coordinator phoned 15 recently discharged patients: 6 did not know when their follow-up was; 5 were unsure about medications; 4 could not name a symptom that should prompt return. Three had been readmitted, two for issues the summary had mentioned but the patient had not understood.

ACTION

A structured discharge conversation was introduced, done by the nurse with the patient and a family member: medications (what, when, why), follow-up (when, where, who), warning signs (three specific symptoms), who to call. A one-page plain-language sheet was completed together. Teach-back: 'Tell me the three things you'll watch for.' Time allocated: 15 minutes per discharge.

AFTER

The Monitor phoned ten recent discharges: all could state follow-up date, medications, and at least two warning signs. Readmission rate at six months: 9%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Phone five patients discharged this week: do they know their follow-up date and warning signs?
2. Watch a discharge — is it a conversation or a handover of paper?
3. Build a one-page plan: medicines, follow-up, three warning signs, who to call.
4. Require teach-back and 15 minutes per discharge.

The most common mistake: Measuring whether the discharge summary was given rather than whether the patient understood it.

SELF-ASSESSMENT QUESTIONS

1. Does every discharged patient receive a documented aftercare plan specific to their situation? — *Not a generic discharge sheet — content specific to this patient's condition and treatment.*

Evidence: Discharge plan sample

2. Can a recently discharged patient explain their own aftercare plan in their own words? — *Tests whether the plan was actually understood, not just handed over.*

Evidence: N/A — tested directly, e.g. follow-up call

3. Does the plan cover medication, warning signs, and who to contact if something goes wrong? — *A plan missing any of these three*

leaves a genuine gap in what the patient needs to manage safely at home.

Evidence: Plan content checklist

COMMON REASONS FOR A PARTIAL ANSWER

- **Plans are individualised for complex cases but generic for routine discharges.** — Perceived complexity often determines effort, even though routine-seeming discharges still carry real risk.
- **The plan is thorough but delivered in the last rushed minutes before the patient leaves.** — Content quality doesn't matter if the delivery moment doesn't allow genuine understanding.
- **Plans are given to the patient but not to an accompanying family member or caregiver, when relevant.**

IMPLEMENTATION PLAN

When	What
Week 1	Review a sample of recent discharge plans for genuine patient-specific content.
Week 2	Build discharge plan delivery into the schedule with real time allocated, not squeezed into a rushed final moment.
Week 3	Train discharging staff to check patient understanding directly before the patient leaves.
Ongoing	Spot-check patient understanding through follow-up contact after discharge.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Discharge plan content review	Reviews a sample of discharge plans for patient-specific content covering medication, warning signs, and contact information.
ASK	Patient understanding check	Contacts or interviews a recently discharged patient to check whether they can describe their own aftercare plan accurately.

Method	What	Detail
OBSERVE	Discharge process observation	Observes how discharge instructions are actually delivered — rushed handover versus a genuine explanation.

SUPERVISOR TIPS

- **Contact a discharged patient directly if possible, rather than relying on the plan document alone.** — The document proves content existed; the patient's recall proves it was actually understood.
- **Observe an actual discharge if the timing allows.** — Rushed, last-minute delivery is a common, specific failure pattern worth seeing directly.

EVIDENCE BASE

Discharge communication quality is consistently identified in patient safety literature as a determinant of post-discharge complications and readmission, distinct from the clinical quality of care received during admission.

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6.2 A Real Mechanism Checks on the Patient After They Leave

NON-NEGOTIABLE

A genuine, defined mechanism exists to check on the patient after discharge — a scheduled call, a follow-up appointment, or an equivalent real contact — not merely "available on request" if the patient happens to reach back out.

In plain terms: Someone checks on every discharged patient — a phone call, an appointment, a visit — as a routine, not just if the patient calls with a problem.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The patient who deteriorates at home does not always call. They may not recognise the symptom, may not want to be a bother, may not have the number. A scheduled contact — a nurse's phone call 48 hours after discharge, a follow-up appointment booked before leaving — catches the problem early. It is also the hospital's only source of truth about whether discharge actually worked: the medications were collected, the wound is healing, the patient understood. 'The patient can call us' is not a mechanism; it is an invitation most will not take up.

WHAT GOOD LOOKS LIKE

- A defined, proactive follow-up mechanism is applied consistently to every discharge.
- Follow-up completion is tracked and verifiable, not dependent on individual memory.
- A clear escalation path exists and is used when follow-up reveals a concern.

COMMON FAILURE MODES

- Follow-up happens only if the patient calls back with a problem.
- No tracking exists to confirm follow-up actually happened for a given patient.
- Staff are uncertain what to do if a follow-up call reveals a concerning symptom.

WORKED EXAMPLE

IN PRACTICE

A 130-bed hospital that told patients to 'contact us with any concerns.'

BEFORE

No follow-up was arranged unless the doctor requested it. The Coordinator found that 40% of discharged patients had no scheduled contact. Of those who had a follow-up appointment, 25% did not attend and nobody followed up on the non-attendance. A patient with a post-operative wound infection was readmitted 9 days after discharge; she had noticed redness on day 3 but 'didn't want to fuss.'

ACTION

A discharge nurse was assigned to phone every patient 48–72 hours after discharge using a five-question script: medications collected? Taking them? Any new symptoms? Wound/condition as expected? Follow-up date known? Calls were logged; concerns were escalated the same day. Non-attendance at follow-up triggered a call.

AFTER

The Monitor reviewed the call log: 240 calls in one month, 22 concerns escalated, 4 early readmissions prevented per nurse notes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count what proportion of discharges have any scheduled follow-up contact.
2. Assign one person to phone every discharge at 48 hours with five questions.
3. Log every call and every concern.
4. Follow up any missed appointment with a call.

The most common mistake: Relying on the patient to call — the ones who need it most are the ones who won't.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined mechanism to actively check on patients after discharge, not just availability on request? — *The facility initiating contact, not merely being reachable if the patient calls first.*

Evidence: Follow-up protocol document

2. Does the mechanism apply consistently, not only for cases staff happen to remember? — *A follow-up system that depends on individual staff memory is not a reliable system.*

Evidence: Follow-up completion log

3. Is there a defined escalation if a follow-up contact reveals a concerning symptom or complication? — *Detecting a problem during follow-up is only useful if something happens as a result.*

Evidence: Escalation protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Follow-up happens reliably for high-risk discharges but inconsistently for routine ones.** — Perceived risk level often determines effort, though routine discharges still carry genuine risk of missed complications.
- **A follow-up call is made but doesn't ask specific enough questions to catch a real problem.** — A generic "how are you feeling" check may miss a specific warning sign a targeted question would catch.
- **Follow-up is attempted but not completed if the patient doesn't answer the first call.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent discharges for evidence of actual follow-up contact, not just a policy that one should occur.
Week 2	Define a specific follow-up mechanism, timing, and content — what questions get asked.
Week 3	Build a simple tracking log so follow-up completion is verifiable, not assumed.
Ongoing	Review the escalation protocol periodically, particularly for cases where a real concern was caught.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Follow-up protocol and log review	Reviews the defined follow-up mechanism and checks completion records against actual recent discharges.
OBSERVE	Follow-up contact sample check	Checks whether a sample of recently discharged patients actually received the defined follow-up contact.
ASK	Escalation protocol interview	Asks staff what happens if a follow-up contact reveals a concerning symptom.

SUPERVISOR TIPS

- **Ask for a completion log, not a description of the intended process.** — A tracked, verifiable record is the only real evidence the mechanism functions consistently.
- **Ask about retry attempts for patients who don't answer the first follow-up call.** — The hardest-to-reach patients are sometimes also the highest-risk ones.

EVIDENCE BASE

Structured post-discharge follow-up contact is associated with earlier identification of complications and reduced avoidable readmission in health services literature, distinct from the quality of the discharge plan itself.

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

NON-NEGOTIABLE

A complaint or feedback channel exists that a patient can use after they've left the facility, with evidence that complaints are genuinely read and acted on, not merely collected.

In plain terms: Patients can complain after they have gone home, the complaints are read by someone who can act, and there is evidence that complaints have changed something.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Complaints are free quality data. A patient who complains is telling you where the system failed — and the ones who complain after leaving are the ones with the most perspective. A complaint form in the waiting room is useless to someone at home. There needs to be a phone

number, an email, a web form, or a postal address that works from outside — and someone who reads it, responds, and connects it to improvement. The standard's test is evidence: not that complaints are received, but that at least one thing has changed because of one.

WHAT GOOD LOOKS LIKE

- A clear, accessible complaint channel exists for patients after they've left.
- Sampled complaints show genuine responses, not just acknowledgment of receipt.
- At least one documented instance exists of a complaint leading to a real practice change.

COMMON FAILURE MODES

- No channel exists beyond an in-person suggestion box, unusable after discharge.
- Complaints are collected but show no evidence of response.
- Nobody can recall a complaint ever leading to any change in practice.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital with a complaints box in the lobby.

BEFORE

The only way to complain was the lobby box, emptied monthly. Nothing existed for post-discharge complaints. The box had received 8 complaints in a year; none had a recorded response; none had led to any change. Discharged patients who phoned the switchboard were told to 'write a letter.'

ACTION

A complaints email and a direct phone line were created and printed on every discharge sheet. A named complaints officer logged each complaint, acknowledged within 5 working days, investigated, and responded within 30. Complaints were reviewed monthly for patterns; each pattern got an action. A 'You said, we did' board was put in the lobby.

AFTER

The Monitor reviewed the log: 34 complaints in six months, all acknowledged and responded to;

5 changes made and posted publicly. Interviewed a patient whose complaint about discharge timing had led to a change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Try to complain about your own hospital from outside — by phone, email, web. How hard is it?
2. Put a complaints email and phone number on every discharge sheet.
3. Name one person who logs, acknowledges, and responds to every complaint.
4. Find one complaint from the last year that could have led to a change — and make it.

The most common mistake: Collecting complaints without responding to them or connecting them to improvement — a complaints box that changes nothing is a decoy.

SELF-ASSESSMENT QUESTIONS

1. Can a patient submit a complaint or feedback after leaving the facility, not only while present? — *A suggestion box in the waiting room alone doesn't meet this — there needs to be a way to reach the facility afterward too.*

Evidence: Complaint channel description, e.g. phone/email/form

2. Is there evidence complaints are actually read and result in a response, not just filed? — *A collected complaint with no follow-through provides no real value to the patient or the facility.*

Evidence: Complaint response record sample

3. Have any complaints led to a documented change in practice? — *A complaint system that has never once led to a change is worth questioning, not just checking for the existence of a form.*

COMMON REASONS FOR A PARTIAL ANSWER

- **A channel exists but isn't clearly communicated to patients before they leave.** — Availability that patients don't know about functions similarly to no availability at all.
- **Complaints receive an acknowledgment but not a substantive response addressing the actual concern.** — A form-letter

acknowledgment can satisfy the letter of "responding" while providing no real value.

- **Serious complaints are reviewed and acted on; minor ones accumulate without individual response.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current complaint channel accessibility, particularly for discharged patients.
Week 2	Ensure the channel is clearly communicated as part of the discharge process.
Week 3	Establish a defined response process and timeframe for submitted complaints.
Ongoing	Track and periodically review whether complaints are leading to real practice changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Post-discharge channel accessibility check	Verifies a real, accessible way exists for a discharged patient to submit a complaint or feedback.
DOCUMENT	Response record review	Reviews a sample of submitted complaints for evidence of an actual response, not just receipt.
DOCUMENT	Practice-change history check	Checks for any documented instance where a complaint led to a specific change in facility practice.

SUPERVISOR TIPS

- **Ask how a discharged patient would actually find and use the complaint channel.** — Theoretical availability and genuine patient-facing accessibility aren't always the same.
- **Ask for a specific example of a complaint that changed something.** — A real example, or its honest absence, reveals more than a description of the general process.

EVIDENCE BASE

Patient complaint systems with demonstrated action on findings are identified in patient safety literature as a distinct quality signal from complaint volume alone — the presence of a channel says little without evidence it functions.

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