

Hospital Standards — Full Guidance

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

17 standards · 143 criteria · Version 4.0

ASF STANDARDS · HOSPITAL · STANDARD 7

Standard 7 — Governance & Management

13 criteria · 10 non-negotiable · 3 core · Version 3.0

CRITERIA IN THIS STANDARD

- 7.1 — The Board Is Real and Accountable
- 7.2 — There Is a Written Strategic Plan
- 7.3 — Policy Actually Gets Followed
- 7.4 — Patient Information Stays Private
- 7.5 — Medical Records Are Complete
- 7.6 — Patient Data Is Kept Secure
- 7.7 — Records Are Kept Exactly as Long as Required
- 7.8 — Incidents Are Actually Reported
- 7.9 — Serious Incidents Get Properly Investigated
- 7.10 — Safety Culture Is Actually Measured
- 7.11 — Patient Experience Is Measured Continuously, Not Only After Discharge
- 7.12 — A Real Ethics Consultation Process Exists
- 7.13 — Patients and Families Have a Real Voice in Governance

7.1 The Board Is Real and Accountable

NON-NEGOTIABLE

A governing body exists, with named members and clear, documented authority over safety and quality, clinical governance, and financial stewardship — not an informal ownership arrangement functioning without real oversight structure.

In plain terms: There is a real governing body with named members and written authority over safety and quality — not just an owner making decisions informally.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

Someone has to be accountable for the whole hospital — not for the surgery department or the finances, but for whether patients are safe. In a hospital without a governing body, that responsibility floats. Decisions about safety compete with decisions about money with no forum to weigh them. A board with named members, terms of reference, minutes, and a standing agenda item on quality and safety creates the forum. It also creates accountability: when something goes wrong, there is a body that should have known, asked, and acted. Ownership is not governance; a sole owner needs a board more, not less.

WHAT GOOD LOOKS LIKE

- Governance charter names members, terms, and quorum rules in writing.
- Quality and safety data is reviewed at every meeting, not only annually.
- Minutes show specific follow-up actions with

COMMON FAILURE MODES

- Governing body exists on paper only; no minutes can be produced.
- Meetings occur but only discuss budget and construction, never outcomes.
- Quality incidents are known to management for

named owners and
deadlines.

months before the board
hears of them.

WORKED EXAMPLE

IN PRACTICE

A 110-bed private hospital owned by two physicians.

BEFORE	The owners made all decisions between themselves. There was no board, no minutes, no defined responsibility for quality. When a serious incident occurred, no one could say who was accountable for the response. The quality committee reported to the medical director, who reported to the owners informally.
ACTION	A governing board was constituted with the two owners, the medical director, the nursing director, an external clinical member, and a patient representative. Terms of reference defined its authority over safety and quality. It met quarterly with minutes and a standing safety report (incidents, infections, complaints, audits). The quality committee reported to the board formally.
AFTER	The Monitor reviewed the terms of reference, membership, and minutes of three meetings with safety reports and actions. Interviewed the external member who described the board's role. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask: who is ultimately accountable for patient safety here? If the answer is a person, not a body, that is the gap.
2. Constitute a board with at least one external member and one patient representative.
3. Write terms of reference: what the board decides, how often it meets, what it receives.
4. Put safety and quality first on every agenda, with a written report.

The most common mistake: Having a board that meets only to discuss finances and hears about quality only when something goes badly wrong.

SELF-ASSESSMENT QUESTIONS

1. Is there a documented governing body with named members and defined terms of office? — *A charter or bylaws naming members and terms, not an informal ownership arrangement.*

Evidence: Governance charter or bylaws

2. Does the governing body meet on a fixed schedule with minutes retained? — *Minutes showing attendance, decisions, and follow-up actions, not just that a meeting occurred.*

Evidence: Meeting minutes, last four

3. Does the board formally review quality and safety performance at each meeting, not only financial performance? — *A standing quality agenda item with real data discussed, not an afterthought.*

Evidence: Quality report presented to governing body

4. Is clinical governance — oversight of clinical effectiveness, audit, and risk — explicitly assigned to a named board responsibility? — *A distinct, named accountability for clinical governance, not assumed to be covered by discussing quality in general terms.*

Evidence: Board terms of reference

5. Is financial stewardship a defined board responsibility distinct from day-to-day financial management? — *Board-level financial oversight, not only operational finance handled by management alone.*

Evidence: Board terms of reference, finance committee minutes

COMMON REASONS FOR A PARTIAL ANSWER

- **The board meets regularly but the quality agenda item is a formality with no real discussion.** — Presence on the agenda doesn't guarantee genuine engagement with the content.
- **Minutes exist but record attendance only, not actual decisions taken.** — A record of who was present says nothing about what was actually decided.
- **One board member drives all quality engagement, with others largely passive.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent board minutes for genuine quality discussion versus formality.
Week 2	Add or reinforce a standing quality and safety agenda item with real data presented.
Week 3	Identify the reporting pathway gap between incident/quality data and board-level visibility, if one exists.
Ongoing	Track board-level follow-up actions to closure, not just to being raised.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Charter and minutes review	Reviews the governance charter and recent minutes for quorum, attendance, and whether quality data led to tracked follow-up.
ASK	Board member interview	Asks a governing body member, without the CEO present, to describe the last quality or safety issue the board acted on.
OBSERVE	Reporting line check	Traces whether incident reports and quality indicators actually reach board level, or stop at management.

SUPERVISOR TIPS

- **Ask for the last four sets of minutes, not the charter alone.** — A polished charter proves nothing about actual practice.
- **Interview a board member alone, not with the CEO present.** — If a board member cannot answer without looking to the CEO, oversight is not independent in practice, whatever the bylaws say.

EVIDENCE BASE

[12] Jha AK, Epstein AM. Hospital governance and the quality of care. Health Aff (Millwood). 2010;29(1):182-187 — hospitals whose boards spent more time on quality performed significantly better on process-of-care measures.

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7.2 There Is a Written Strategic Plan

NON-NEGOTIABLE

A documented plan states the hospital's mission, values, and a code of conduct for staff behaviour, and genuinely guides resourcing decisions — not a one-page mission poster disconnected from how money and staff time actually get allocated, and not a mission statement with no accompanying statement of values or expected conduct.

In plain terms: The hospital has a written strategy that actually guides where money and staff go — not a mission statement on the wall that nobody uses to decide anything.

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

WHY THIS MATTERS

Without a strategy, resources follow whoever asks loudest. The surgeon gets the new machine; the ward that needs another nurse gets nothing. A strategic plan states what the hospital is for, what it will prioritise over the next three to five years, and therefore what it will say no to. It becomes real when the budget process references it — when a request is evaluated against the plan. The test is not whether the plan exists but whether anyone can point to a decision it shaped.

WHAT GOOD LOOKS LIKE

- The plan names the population served, concrete goals, and a resourcing rationale.
- Front-line staff across departments describe a consistent, recognisable mission.

COMMON FAILURE MODES

- The plan is a one-page mission poster with no operational content.
- Staff across departments give inconsistent or vague descriptions of the hospital's mission.

- At least one recent resourcing decision is clearly traceable to a stated strategic priority.

- No resourcing decision can be linked back to anything in the written plan.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital with a framed mission statement in the lobby.

BEFORE

The mission said 'excellence in compassionate care.' There was no strategic plan. Budget was set by adjusting last year's numbers. When the Coordinator asked department heads how resources were allocated, the answer was 'we ask the Director.' No one could name a strategic priority.

ACTION

The board ran a half-day planning session and produced a four-page strategy: three priorities for three years (maternal care, infection control, staff retention), with a measurable goal for each. The next budget cycle required every capital request to state which priority it served. Two requests were declined because they served none.

AFTER

The Monitor reviewed the strategy, the budget with priority alignment column, and minutes showing a declined request. Asked two department heads the three priorities; both answered. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five managers what the hospital's top priority is this year. If you get five answers, there is no strategy.
2. Hold a half-day session with the board to agree three priorities.
3. Write them on four pages, each with one measurable goal.
4. Add a column to the budget request form: 'Which priority does this serve?'

The most common mistake: Confusing a mission statement with a strategy — a mission says why; a strategy says what, when, and therefore what not.

SELF-ASSESSMENT QUESTIONS

1. Is there a written strategic plan covering at least a multi-year horizon? — *Not an annual budget alone — a plan with genuine forward horizon.*

Evidence: Strategic plan document

2. Does the plan include a clear mission statement describing who the hospital serves and how? — *Specific enough to guide real decisions, not generic enough to apply to any hospital anywhere.*

Evidence: Mission statement text

3. Can a resourcing decision from the last year be traced back to something in the plan? — *Tests whether the plan actually influences decisions, not just whether it exists.*

Evidence: Example resourcing decision with plan linkage

4. Does the hospital have a documented statement of values and a code of conduct distinct from the mission statement, genuinely guiding staff behaviour? — *A real, specific statement of expected conduct, not a mission statement alone standing in for it.*

Evidence: Values/code of conduct document

COMMON REASONS FOR A PARTIAL ANSWER

- **A plan exists and is well written but was never actually communicated to front-line staff.** — Quality of the document doesn't matter if it never reaches the people expected to align with it.
- **The plan states priorities but the annual budget process runs independently of it.** — Two parallel processes that don't reference each other produce a plan with no real teeth.
- **Leadership can trace decisions to the plan; front-line staff cannot see the connection.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the current plan for specificity and whether recent resourcing decisions reference it.

When	What
Week 2	Communicate the plan's core priorities directly to front-line staff, not just leadership.
Week 3	Link the next resourcing or budget decision explicitly and visibly to a stated strategic priority.
Ongoing	Revisit the plan on a fixed schedule, not only when it happens to come up.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Plan and minutes cross-check	Reviews the strategic plan against governing body minutes to check for genuine linkage to real decisions.
ASK	Front-line staff interview	Asks staff from different departments to state the hospital's mission in their own words.
OBSERVE	Wall and induction material check	Checks whether the mission is genuinely integrated into staff-facing materials, not only leadership documents.

SUPERVISOR TIPS

- **Ask staff in different departments the same question separately.** — Consistency across independent answers reveals genuine organisational alignment.
- **Ask for one specific recent decision and trace its rationale.** — A real, traceable example is worth more than a general assurance the plan guides decisions.

EVIDENCE BASE

[11] Institute for Healthcare Improvement. Framework for effective board governance of health system quality. Boston: IHI; 2018 — identifies strategic alignment between stated mission and resource allocation as a determinant of sustained quality improvement.

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7.3 Policy Actually Gets Followed

NON-NEGOTIABLE

A policy framework exists and staff can describe how it's genuinely applied in practice, not merely confirm that policies are filed and technically available. The framework includes a formal, comprehensive quality improvement plan covering every part of the hospital, with allocated responsibilities and defined performance indicators.

In plain terms: Policies exist, and staff can describe how they actually apply them in real situations — not just confirm the binder is on the shelf.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Every hospital has policies. Most sit in binders or on shared drives, written for accreditation, never read. A policy that is not known is not a policy; it is a document. The test is whether a nurse on the ward can say what the hand hygiene policy requires of her, or what the medication policy says to do about a verbal order. If she can, the policy is alive. If she has to look it up, or does not know it exists, the hospital's actual practice is whatever each person decides. The standard asks for evidence of application, not existence.

WHAT GOOD LOOKS LIKE

- Staff describe specific, genuine application of policy in their actual work.
- A real adherence-checking mechanism exists, distinct from document filing.
- Identified gaps between policy and practice trigger a defined, followed response.

COMMON FAILURE MODES

- Staff can confirm policies exist but cannot describe how they actually apply to daily work.
- No mechanism exists to verify adherence beyond confirming documents are filed.
- Known gaps between policy and practice persist without any response.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital with 180 policies on a shared drive.

BEFORE

The Coordinator asked ten staff to describe three policies relevant to their role. Two could describe one policy. Most did not know where policies were kept. Several policies contradicted current practice; some referred to departments that no longer existed. The last review date on most was five years earlier.

ACTION

The policy set was reduced to 40 essential documents, each two pages or less. Each had a named owner and a review date. Every policy was linked to a training or briefing: the ten most critical (hand hygiene, medication, identification, consent, incident reporting) were covered at induction and annual refresher. A monthly 'policy of the month' briefing was added to ward meetings.

AFTER

The Monitor asked eight staff to describe two policies relevant to their role; seven could. Reviewed the policy register with owners and dates. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five staff to describe one policy they follow daily. Note how many can.
2. Count your policies. If over 60, most are unread.
3. Reduce to the essential set, each two pages, each with an owner.
4. Link every critical policy to a training moment.

The most common mistake: Producing more policies to satisfy an audit when the problem is that existing ones are unknown.

SELF-ASSESSMENT QUESTIONS

1. Can staff describe how a specific, named policy is actually applied in their daily work? — *Not whether they know a policy exists — whether they can describe applying it.*

Evidence: N/A — tested directly

2. Is there a mechanism to check policy adherence, not just policy existence? — *A policy audit or spot-check process, distinct from simply confirming documents are filed.*

Evidence: Policy adherence audit record

3. When a policy-practice gap is found, is there a defined response, not just noting the discrepancy? — *Identifying a gap without addressing it provides limited real value.*

Evidence: Gap resolution record

4. Is there a single, formal quality improvement plan comprehensive across governance, clinical governance, organisational management, utilisation and efficiency of services, and quality performance — with named responsibilities and defined indicators? — *See the [ASF Indicator Programme](#) for the recommended indicator set. A genuinely comprehensive plan, not isolated initiatives in individual departments.*

Evidence: QI plan document

5. Is the quality improvement plan itself formally evaluated on a defined schedule, with the evaluation used to revise the plan? — *A plan that is reviewed and updated, not adopted once and left static.*

Evidence: QI plan review record

6. Is every policy, procedure and plan formally authorised by a named person with the authority to approve it, with that authorisation genuinely recorded? — *A recorded sign-off by someone with real authority to approve it, not a document that simply appeared without a traceable approval.*

Evidence: Document approval record

7. Is every policy, procedure and plan reviewed against a defined timescale to confirm it's still current? — *A genuine scheduled review date, not a document approved once and never revisited.*

Evidence: Document review schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **Policies are followed for well-established practices but not consistently for newer ones.** — Established habit reinforces old policy adherence; new policies need active reinforcement to take hold.
- **An adherence check exists but only samples a small, easily-prepared subset of practice.** — A narrow or predictable audit scope can miss where real gaps live.
- **Gaps are identified during audits but corrective action isn't consistently tracked to completion.**

IMPLEMENTATION PLAN

When	What
Week 1	Select several key policies and ask a sample of staff to describe their actual application.
Week 2	Establish or reinforce a genuine adherence-checking mechanism, not just document review.
Week 3	Build a tracked resolution process for any policy-practice gap identified.
Ongoing	Rotate which policies get checked, avoiding a predictable, easily-prepared audit pattern.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff application interview	Asks a staff member to describe how they actually apply a specific named policy in their work, not to recite its existence.
DOCUMENT	Adherence audit review	Checks for evidence of any process verifying policy adherence, beyond confirming documents are filed.
OBSERVE	Practice-policy comparison	Directly observes a practice area and compares actual behaviour against the stated policy for that area.

SUPERVISOR TIPS

- **Ask about application, not existence.** — "Do you know this policy exists" and "how do you actually apply it" surface very different answers.

- **Pick a policy area to observe directly, not just review on paper.**
 - Direct observation reveals gaps document review alone cannot.

EVIDENCE BASE

Policy-practice gaps are consistently identified in healthcare quality literature as a distinct failure mode from policy absence — the existence of a written policy is not evidence of its implementation.

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7.4 Patient Information Stays Private

NON-NEGOTIABLE

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

In plain terms: Patient information is kept private in practice — no charts left open, no conversations in corridors, no screens visible to visitors — not just in a policy.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Confidentiality is broken by habit, not malice: the chart on the trolley in the corridor, the diagnosis discussed at the nurses' station within earshot of the waiting room, the computer screen facing the door, the whiteboard listing every patient's condition. Each one is a small betrayal that patients notice and remember. In some contexts — HIV, mental illness, pregnancy — a breach can end a marriage, a job, or a life. The policy is the easy part. The hard part is the culture: a hospital where staff automatically lower their voices and close the chart because that is simply what one does.

WHAT GOOD LOOKS LIKE

- Screens and monitors are consistently positioned away from public view.
- Clinical conversations happen in genuinely private spaces, doors or curtains actually used.
- Staff describe specific, habitual privacy practices without needing to reference a policy document.

COMMON FAILURE MODES

- Screens face waiting areas or corridors, visible to anyone passing.
- Clinical conversations are regularly audible to other patients.
- Staff can cite the confidentiality policy but describe no specific practical habits.

WORKED EXAMPLE

IN PRACTICE

A 130-bed hospital with a written confidentiality policy.

BEFORE

The Coordinator walked the wards: charts open on trolleys in public corridors; a whiteboard at the nurses' station listing patient names and diagnoses visible from the lift; a doctor discussing a patient's HIV result with a colleague in the waiting area. Computer screens at reception faced the queue. Staff had signed the policy at induction.

ACTION

Whiteboards were moved behind the station or replaced with initials only. Chart trolleys were fitted with covers. Computer screens were turned and fitted with privacy filters. A 'quiet room' was designated on each ward for sensitive conversations. A 10-minute confidentiality-in-practice briefing with real examples was added to ward meetings. Monthly walk-rounds by the ward manager checked for breaches.

AFTER

The Monitor walked three wards: no open charts, no visible diagnoses, screens shielded. Observed a doctor take a family into the quiet room for a difficult conversation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk through your hospital as a visitor. What patient information can you see or hear?
2. Turn every screen away from public view.
3. Remove diagnoses from any board visible to visitors.
4. Designate a room on each ward for private conversations.

The most common mistake: Having every staff member sign a confidentiality policy while the whiteboard in the corridor lists every patient's diagnosis.

SELF-ASSESSMENT QUESTIONS

1. Are screens and monitors positioned so patient information isn't visible to passersby or other patients? — *Physical positioning, checked directly, not assumed from a policy statement.*
Evidence: Photo audit of screen positioning

2. Are clinical conversations conducted where they can't be overheard by other patients or visitors? — *Curtains, closed doors, or private spaces genuinely used, not just available.*
Evidence: N/A — tested directly

3. Do staff understand and apply confidentiality practices consistently, not only when reminded? — *Tests whether privacy protection is habitual, not situational.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Physical privacy is good in some areas but overlooked in others, like corridors or shared bays.** — Privacy protection is often strongest where it was deliberately designed and weaker in less-considered spaces.
- **Staff are conscientious about privacy when reminded but inconsistent otherwise.** — Habitual practice is a different, more reliable thing than practice prompted by reminder.
- **Curtains or private spaces exist but aren't consistently used under time pressure.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit screen positioning and conversation privacy across all patient-facing areas.
Week 2	Reposition screens and reinforce use of private spaces where gaps are found.
Week 3	Brief staff specifically on habitual, not just reminded, confidentiality practice.
Ongoing	Spot-check physical privacy periodically, including in less-considered shared spaces.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Physical privacy check	Walks through patient-facing areas checking screen positioning, conversation privacy, and general physical confidentiality protection.
OBSERVE	Conversation audibility check	Checks whether clinical conversations happening in the facility can be overheard from adjacent areas.
ASK	Staff practice interview	Asks staff to describe specific ways they protect patient confidentiality in their daily work, beyond citing the policy.

SUPERVISOR TIPS

- **Walk the space as a visitor would, checking what's actually visible or audible.** — A staff member's familiar routine can make an obvious privacy gap invisible to them.
- **Ask staff for specific examples of their own privacy practices.** — Specific, concrete habits reveal genuine internalisation better than reciting the policy.

EVIDENCE BASE

Patient confidentiality protection frameworks consistently identify physical environment design and staff behaviour, not policy documentation alone, as the practical determinants of actual privacy protection.

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7.5 Medical Records Are Complete

NON-NEGOTIABLE

Records contain all mandatory elements and are genuinely audited for completeness on a regular basis, not assumed complete because a template exists.

In plain terms: Medical records contain everything they should, and someone regularly audits a sample to check — not just assumes the template makes them complete.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The medical record is the only account of what happened to the patient. When it is incomplete, the next clinician does not know the allergy, the court does not know the consent was taken, the audit does not know the antibiotic was given on time. Incompleteness is invisible until the record is needed for something — a complaint, a lawsuit, a readmission — and then it is too late. A regular audit of a random sample against a checklist of mandatory elements is the only way to know the record is working. A template does not guarantee completion; it guarantees that empty fields have names.

WHAT GOOD LOOKS LIKE

- A specific, defined list of mandatory elements exists for each encounter type.
- Regular, genuine completeness audits are conducted with documented findings.
- Identified gaps are tracked to resolution, not left open.

COMMON FAILURE MODES

- No specific mandatory elements list exists beyond general expectation.
- No audit process exists, or completeness is assumed rather than checked.
- Gaps found in past audits remain unresolved with no tracking.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital with paper records and a defined admission template.

BEFORE	No one audited records. The Coordinator pulled 30 at random against a 15-item checklist (identification, allergies, consent, medication chart, assessment, care plan, discharge summary...). Average completeness: 60%. Consent forms were missing in 8; allergy status was blank in 11. The medical director assumed records were complete 'because the template is good.'
ACTION	A monthly audit was established: 20 random records against a 15-item checklist, scored by the medical records officer, reported by ward and by clinician. Results went to the quality committee. Wards below 85% received a targeted briefing. The three most-missed items were added to the discharge sign-off.
AFTER	The Monitor reviewed six months of audit results: completeness up from 60% to 91%. Reviewed the checklist and the quality committee minutes with actions. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull 20 records at random and check 15 mandatory items. Score them.
2. Identify the three most-missed items.
3. Start a monthly audit with results by ward.
4. Report the score to the quality committee and ward managers.

The most common mistake: Trusting the template — a template with blank fields is an incomplete record with a nice layout.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined list of mandatory record elements for each type of encounter? — *A specific, checkable list, not a general expectation of thoroughness.*

Evidence: Mandatory elements list

2. Are records regularly audited for completeness against that list? — *Genuine audit, not assumption of completeness because a template was used.*

Evidence: Completeness audit record

3. Are gaps found during audits actually addressed, not just noted? — *Identifying an incomplete record without correcting it leaves the underlying risk unresolved.*

Evidence: Gap resolution record

COMMON REASONS FOR A PARTIAL ANSWER

- **Audits happen but only sample a small, non-representative set of records.** — A narrow sample can miss where real completeness gaps concentrate.
- **Completeness is checked for structural fields but not for genuine clinical content quality.** — A record can be structurally complete while still lacking substantively useful clinical detail.
- **Gaps are found and noted but resolution isn't consistently tracked to closure.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the current mandatory elements list and recent audit practice, if any exists.
Week 2	Establish or reinforce a genuine, regular completeness audit process.
Week 3	Build a gap resolution tracker so identified issues are actually closed.
Ongoing	Widen the audit sample periodically to avoid a narrow, predictable pattern.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Mandatory elements definition check	Reviews the defined list of mandatory record elements for specificity and completeness.
DOCUMENT	Completeness audit review	Reviews recent completeness audit records and checks for genuine, regular practice.
DOCUMENT	Gap resolution check	Checks whether gaps identified in past audits were actually resolved, not just documented as found.

SUPERVISOR TIPS

- **Ask for actual audit records, not a description of the intended process.** — Dated findings are the only real evidence a genuine audit occurs.
- **Check whether a past identified gap was actually resolved.** — Resolution tracking reveals whether the audit process has real teeth.

EVIDENCE BASE

Medical record completeness auditing is a recognised quality assurance practice specifically because template existence alone does not guarantee consistent completion in real clinical practice.

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7.6 Patient Data Is Kept Secure

NON-NEGOTIABLE

Health information is protected with defined access controls and a genuine breach response plan, using practical, achievable security measures appropriate to the facility's resources.

In plain terms: Patient data is protected with practical access controls and a plan for what to do if there is a breach — appropriate to the hospital's real situation, not a policy copied from a large corporation.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A hospital's records are attractive: identity data, financial data, health data. Breaches happen through lost laptops, shared passwords, unlocked records rooms, and staff looking up patients out of curiosity. The standard does not require enterprise security; it requires the basics done properly: who can access what, how access is granted and removed when someone leaves, where paper records are kept and who has the key, and what happens when a breach is discovered. A breach response plan matters because breaches will happen; the difference is whether the hospital knows within hours or months.

WHAT GOOD LOOKS LIKE

- Access controls are genuinely role-based and reflect actual staff need.
- A specific, actionable breach response plan exists and has been reviewed recently.
- Relevant staff know their role in the breach response process.

COMMON FAILURE MODES

- Data access is broadly available regardless of staff role.
- No breach response plan exists, or it exists only as a vague statement of concern.
- Staff are unaware any breach response process exists.

WORKED EXAMPLE

IN PRACTICE

A 120-bed hospital with an electronic record system and a paper archive.

BEFORE

All clinical staff shared two system logins. Departed staff still had accounts. The paper archive was in an unlocked basement room. There was no breach plan. When a USB stick

	with a patient list was lost, nobody knew who to tell or what to do.
ACTION	Individual logins were issued to every user with role-based access. A leaver process removed access on the last day. The archive was locked with a signed key register. A one-page breach response plan named the person to notify, the steps to contain and assess, and the reporting obligations. Two staff completed a half-day data protection course.
AFTER	The Monitor reviewed the access list (individual, role-based, no leavers), the archive key register, and the breach plan. Asked a nurse what she would do if she found a patient list in a public area; she named the person to call. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count how many people share a login. Anything above one is a gap.
2. Check whether staff who left last year still have accounts.
3. Lock the paper archive and start a key register.
4. Write a one-page breach plan: who to tell, what to do first.

The most common mistake: Adopting a 40-page data security policy from a large hospital that nobody in a small one can implement — do the basics, and do them properly.

SELF-ASSESSMENT QUESTIONS

1. Are access controls in place restricting patient data access to staff who need it for their role? — *Role-based restriction, not general access available to any staff member.*

Evidence: Access control policy and implementation

2. Is there a documented breach response plan, specific and actionable? — *Not a general statement of concern — a named process for what happens if a breach occurs.*

Evidence: Breach response plan document

3. Have access controls and the breach plan been reviewed or tested recently? — *An untested plan or unreviewed control list may not reflect current reality.*

Evidence: Review or test record

COMMON REASONS FOR A PARTIAL ANSWER

- **Access controls exist for electronic records but not consistently for physical files.** — Security attention often concentrates on digital systems while physical record access remains loosely controlled.
- **A breach response plan exists but has never been reviewed since it was written.** — An unreviewed plan may not reflect current systems, staff, or actual risk.
- **Access controls are correctly configured but not periodically re-reviewed as staff roles change.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current access controls against actual staff roles for any over-broad access.
Week 2	Draft or review the breach response plan for specificity and actionable steps.
Week 3	Brief relevant staff on their role in the breach response process.
Ongoing	Review access control assignments periodically as staff roles change.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Access control review	Reviews access control policy and checks implementation against actual staff access levels.
DOCUMENT	Breach response plan check	Reviews the breach response plan for specificity and actionable steps, not general statements.
ASK	Staff awareness interview	Asks staff whether they know the breach response process and their role in it, if applicable.

SUPERVISOR TIPS

- **Check physical record access, not only electronic systems.** — Security attention often skews toward digital systems while physical files remain loosely controlled.
- **Ask when the breach plan was last reviewed, not just whether it exists.** — A plan's age relative to current systems and staff matters as much as its existence.

EVIDENCE BASE

Health information security frameworks consistently identify access control and incident response planning, rather than technology sophistication alone, as the primary determinants of practical data protection in resource-constrained settings.

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7.7 Records Are Kept Exactly as Long as Required

NON-NEGOTIABLE

A retention policy governs how long records are kept and how they're disposed of, aligned with the specific legal requirement in this facility's jurisdiction, not a generic assumption.

In plain terms: Records are kept for exactly as long as your country's law requires, and destroyed securely after — under a written retention policy that names the legal source.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Keep records too briefly and you cannot defend a lawsuit, respond to a complaint, or give a patient their history. Keep them forever and the archive fills a basement, costs money, and breaches privacy law in jurisdictions that mandate deletion. The retention period is not a

judgment call; it is a legal requirement that differs by country, record type, and patient age. A written policy that cites the specific law, states the period for each record type, and defines the secure destruction method is the only defensible position. Most hospitals have no such policy and simply keep everything.

WHAT GOOD LOOKS LIKE

- A specific, written retention policy exists by record type.
- Retention periods are verified against actual legal requirements, not assumed.
- Disposal is conducted securely with documented records.

COMMON FAILURE MODES

- No specific retention policy exists beyond a general assumption.
- Stated retention periods don't match the actual legal requirement, or were never checked.
- No evidence of secure, documented disposal exists.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital with 25 years of paper records in a basement and no retention policy.

BEFORE

Nobody knew the legal retention period. Records were never destroyed. The basement was full and damp; some records from the 1990s were unreadable. When the Coordinator checked, the national law required 10 years for adult records, 25 years for children, and permanent retention for certain categories — the hospital was both over-retaining most records and had let some required ones decay.

ACTION

The Coordinator obtained the legal requirement from the Ministry of Health and wrote a two-page policy: record type, retention period, legal source, destruction method (shredding with certificate), and responsible person. A destruction schedule was created for records beyond retention. Records still within retention were moved to dry storage. A destruction log was started.

AFTER

The Monitor reviewed the policy with legal citations, the destruction schedule, the destruction log with certificates, and the improved storage. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find out the legal retention period for medical records in your country — ask the Ministry or a lawyer.
2. Write it down with the source, by record type.
3. Identify records past retention and schedule secure destruction.
4. Check that records within retention are stored where they will survive.

The most common mistake: Keeping everything forever because nobody knows the rule — over-retention is both a cost and a privacy risk.

SELF-ASSESSMENT QUESTIONS

1. Does a written retention policy exist, specifying how long different record types are kept? — *Specific durations by record type, not a vague general statement.*

Evidence: Retention policy document

2. Is the retention period aligned with the actual legal requirement in this jurisdiction? — *Verified against the real legal requirement, not assumed or copied from another context.*

Evidence: Legal requirement reference

3. Is disposal of records past their retention period conducted securely and documented? — *Disposal that protects confidentiality even as the record is destroyed.*

Evidence: Disposal record

COMMON REASONS FOR A PARTIAL ANSWER

- **A policy exists but was written years ago and never checked against a legal requirement update.** — Legal requirements can change, and a policy set once can quietly become outdated.
- **Retention periods are correct for most record types but a specific category was overlooked.** — Comprehensive-looking policies can still miss a specific record type with different legal requirements.

- **Disposal happens but isn't consistently documented.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the current retention policy against the actual legal requirement for this jurisdiction.
Week 2	Correct any misalignment found and update the policy accordingly.
Week 3	Establish a documented, secure disposal process for records past retention.
Ongoing	Recheck legal requirement alignment periodically, as regulations can change.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Retention policy review	Reviews the retention policy for specificity by record type.
DOCUMENT	Legal alignment check	Checks whether the stated retention periods align with the actual legal requirement in this jurisdiction.
DOCUMENT	Disposal record review	Reviews records of secure disposal for any record past its retention period.

SUPERVISOR TIPS

- **Ask for the specific legal citation the retention period is based on.** — A specific reference, or its absence, reveals whether this was genuinely checked or assumed.
- **Check disposal documentation, not just the retention policy itself.** — A correct policy on paper doesn't guarantee correct, documented execution.

EVIDENCE BASE

Health record retention requirements vary by jurisdiction and are legally defined precisely because both premature destruction and indefinite retention carry distinct, documented risks.

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7.8 Incidents Are Actually Reported

NON-NEGOTIABLE

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

In plain terms: Staff actually report incidents — near-misses as well as harm — and the hospital can show it from the number and pattern of reports, not just the existence of a form.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A hospital that reports few incidents is not a safe hospital; it is a hospital where staff have stopped reporting. Incident reports are the raw material of learning: the near-miss today is the death next month if the cause is not found. Staff stop reporting when reports go nowhere, when they are blamed, when the form takes 20 minutes, or when nothing ever changes. The measure of a working system is volume and pattern: reports rising as trust builds, near-misses outnumbering harm events, every ward reporting. A form on the intranet with three reports a month is not a system.

WHAT GOOD LOOKS LIKE

- Reporting volume reflects genuine, ongoing use across staff levels, not just management.
- Staff describe genuine confidence they can report without punitive consequence.

COMMON FAILURE MODES

- Reporting volume is minimal or has dropped sharply with no clear explanation.
- Staff describe fear of blame or consequence as a reason they hesitate to report.

- The reporting system is accessible directly at the point of work.

- The reporting system exists but is difficult to access in practice.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital with an incident form that generated 40 reports a year.

BEFORE

The form was four pages and required the reporter's name and manager's signature. Reports went to the medical director and stayed there. Staff described a colleague who had reported a medication error and been disciplined. Ward nurses estimated they saw 'several' near-misses a week; none were reported.

ACTION

The form was reduced to one page with an anonymous option. A no-blame policy was written and signed by the Director. Reports went to a quality officer who acknowledged each within 48 hours, with the reporter told what was done. Monthly ward feedback showed what was learned. Near-miss reporting was actively encouraged with a 'good catch' recognition.

AFTER

The Monitor reviewed the log: 340 reports in the year, 60% near-misses, every ward reporting, average acknowledgement time 1.5 days. Interviewed three nurses who had reported and received feedback. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count last year's incident reports. Divide by beds. Under 2 per bed per year means under-reporting.
2. Ask five nurses when they last saw a near-miss and whether they reported it.
3. Cut the form to one page and allow anonymous reports.
4. Acknowledge every report within 48 hours and tell the reporter what happened.

The most common mistake: Interpreting a low incident count as a safe hospital — it is almost always a silent one.

SELF-ASSESSMENT QUESTIONS

1. Is the incident reporting system genuinely accessible to all staff, not just management? — *Accessible in practice, at the point of work, not buried in an administrative system.*

Evidence: Reporting system access description

2. Does actual reporting volume suggest genuine use, not just technical availability? — *A system that exists but receives almost no reports over time suggests a use problem, not a safety-perfect facility.*

Evidence: Reporting volume data over time

3. Do staff believe they can report without fear of punitive consequence? — *Genuine psychological safety, not just a stated non-punitive policy.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Reporting happens for minor incidents but staff hesitate to report anything involving their own error.** — Psychological safety often varies by perceived personal exposure, not uniformly across incident types.
- **Senior staff report reliably; junior staff report far less.** — Hierarchy can create very different real experiences of psychological safety within the same facility.
- **A non-punitive policy exists on paper but staff describe a past incident where reporting led to real consequences.**

IMPLEMENTATION PLAN

When	What
Week 1	Review reporting volume trends and identify any concerning drop or pattern.
Week 2	Interview a cross-section of staff, including junior staff, about their actual confidence in reporting.
Week 3	Address any specific past incident or perception undermining psychological safety directly and visibly.
Ongoing	Track reporting volume as an ongoing indicator, investigating any significant drop.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Reporting volume review	Reviews incident reporting volume and pattern over time for evidence of genuine, ongoing use.
ASK	Psychological safety interview	Asks front-line staff directly whether they feel safe reporting an incident, including one they caused themselves.
OBSERVE	System accessibility check	Checks how genuinely accessible the reporting mechanism is at the actual point of work, not just in principle.

SUPERVISOR TIPS

- **Ask junior staff specifically, not only senior staff.** — Hierarchy can create very different real experiences within the same facility.
- **Ask about reporting one's own error specifically, not just witnessing someone else's.** — Self-reporting confidence is usually the harder, more revealing test of genuine psychological safety.

EVIDENCE BASE

Incident reporting culture, specifically the psychological safety staff feel around reporting without fear of punitive consequence, is consistently identified as the primary determinant of reporting volume, more so than system accessibility alone.

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7.9 Serious Incidents Get Properly Investigated

NON-NEGOTIABLE

Root cause analysis is genuinely used for serious incidents, with a resulting, tracked action plan — not a brief note

explaining what happened without examining why it happened.

In plain terms: Serious incidents get a proper root cause analysis with a tracked action plan — not a short note saying what happened and moving on.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

When a patient dies from an error, the question is not 'who did it' but 'why did the system let it happen.' Root cause analysis asks that question systematically: what were the contributing factors — staffing, equipment, communication, training, environment — and what change would prevent recurrence. A brief incident note that records the facts and blames the individual learns nothing; the same error recurs with a different nurse. An RCA produces actions with owners and dates, and those actions are tracked to completion. That is how the hospital gets safer.

WHAT GOOD LOOKS LIKE

- A structured RCA methodology is genuinely applied to serious incidents.
- RCAs consistently result in specific, documented action plans.
- Action items are tracked and demonstrably completed, not left open.

COMMON FAILURE MODES

- Serious incidents receive only a brief note, no structured systemic analysis.
- RCAs identify findings but produce no specific action plan.
- Action items remain open indefinitely with no completion tracking.

WORKED EXAMPLE

IN PRACTICE

A 160-bed hospital where serious incidents were reviewed by the medical director.

BEFORE

A wrong-drug death was investigated with a half-page note: 'Nurse X administered the wrong medication. Nurse X has been counselled.' No

system factors were examined. Six months later, a near-identical error occurred with a different nurse. Nobody had asked why two similar drugs were stored side by side, why the double-check was not done, or why the ward was two nurses short that night.

ACTION

An RCA process was adopted: a trained team of three (not including the involved staff's manager) conducts a structured investigation within 30 days using a recognised method — timeline, contributory factors, root causes, actions with owners and dates. Actions are tracked at the quality committee until closed. The involved staff are supported, not blamed, unless there is reckless conduct.

AFTER

The Monitor reviewed three completed RCAs with contributory factor analysis and action plans; all actions had owners, dates, and closure evidence. The look-alike drug storage issue identified in one RCA had been fixed hospital-wide. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull your last three serious incident investigations. Do they identify system causes or just name a person?
2. Train three people in a recognised RCA method (a two-day course).
3. Define 'serious incident' and the 30-day RCA requirement in writing.
4. Track every RCA action at the quality committee until closed.

The most common mistake: Investigating to find who was at fault rather than why the system allowed it — the person changes; the system stays the same.

SELF-ASSESSMENT QUESTIONS

1. Is a structured root cause analysis method used for serious incidents, not just a brief incident note? — *A defined methodology*

examining systemic factors, not a one-paragraph summary.

Evidence: RCA methodology and completed sample

2. Does the RCA result in a specific, tracked action plan? — Findings without a resulting plan don't translate into prevention.

Evidence: Action plan document

3. Are action plan items tracked to completion, not left open indefinitely? — An action item that's never closed provides no real protection against recurrence.

Evidence: Action plan completion tracking

COMMON REASONS FOR A PARTIAL ANSWER

- **RCA is conducted for the most severe incidents but not consistently applied to moderately serious ones.** — A narrower-than-intended threshold for triggering RCA can leave real systemic issues unexamined.
- **Action plans are written but implementation isn't consistently tracked to actual completion.** — A good plan on paper doesn't guarantee the underlying system issue actually got fixed.
- **RCA identifies contributing factors but stops short of genuinely systemic root causes.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent serious incidents for evidence of genuine RCA versus brief incident notes.
Week 2	Ensure RCA methodology is applied consistently against a clear, defined severity threshold.
Week 3	Build a tracked action plan process ensuring RCA findings translate into completed changes.
Ongoing	Audit action plan completion rates periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	RCA methodology and sample review	Reviews the RCA methodology used and checks a sample of completed analyses for genuine systemic examination.

Method	What	Detail
DOCUMENT	Action plan review	Reviews whether RCAs result in specific, documented action plans, not just findings.
DOCUMENT	Completion tracking check	Checks whether action plan items are tracked to actual completion.

SUPERVISOR TIPS

- **Ask for a completed RCA example, not a description of the methodology.** — A real example reveals whether the analysis goes genuinely systemic or stays surface-level.
- **Check whether action items from past RCAs were actually completed.** — Completion tracking is where good analysis either translates into real prevention or doesn't.

EVIDENCE BASE

Root cause analysis methodology is a well-established patient safety practice specifically because surface-level incident review, without deeper systemic examination, is consistently associated with recurrence of preventable events.

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7.10 Safety Culture Is Actually Measured

NON-NEGOTIABLE

A validated survey measures whether staff genuinely feel safe raising concerns, conducted regularly and acted on, not assumed from the absence of complaints.

In plain terms: The hospital measures whether staff feel safe to raise concerns — with a validated survey, regularly — and acts on what it finds.

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

WHY THIS MATTERS

Safety culture is the difference between a nurse who says 'I think you've got the wrong patient' and one who says nothing because the surgeon shouts. It cannot be assumed from the absence of complaints; silence is the symptom. A validated survey — the AHRQ Hospital Survey on Patient Safety Culture, SAQ, or equivalent — asks staff anonymously: do you feel able to speak up? Are errors held against you? Does management act on safety concerns? The results, by unit, show where the culture is broken. Then the hard part: doing something visible about it.

WHAT GOOD LOOKS LIKE

- A validated safety culture survey is administered on a regular, defined schedule.
- Results are reviewed with genuine analysis, not filed without examination.
- Staff can point to a visible change that resulted from a past survey.

COMMON FAILURE MODES

- No structured survey exists, or an internally improvised, unvalidated tool is used.
- Surveys were conducted once, historically, with no regular schedule since.
- Staff report survey results disappear with no visible follow-up.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital that had never surveyed staff on safety culture.

BEFORE

Management believed the culture was good because there were few complaints. The Coordinator ran the AHRQ survey anonymously: 45% of staff said they felt errors would be held against them; 38% said they would not feel safe raising a concern about a senior doctor. Two units scored far below the rest.

ACTION

Results were shared openly with all staff. The two low-scoring units received focused attention: their leadership was coached, a 'speaking up'

champion was appointed, and the Director attended their meetings. A hospital-wide 'just culture' policy was written and explained. The survey was repeated at 12 months.

AFTER

The Monitor reviewed both survey rounds: 'errors held against you' down from 45% to 22%; the two low-scoring units improved most. Reviewed the action plan and the just culture policy. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Run a validated safety culture survey — the AHRQ tool is free and translated into many languages.
2. Make it anonymous and share the results with everyone.
3. Identify your two lowest-scoring units and focus there.
4. Repeat annually and show the trend.

The most common mistake: Assuming the culture is safe because nobody complains — the absence of complaints is what an unsafe culture produces.

SELF-ASSESSMENT QUESTIONS

1. Is a validated safety culture survey conducted, not an informal or ad hoc check? — *A recognised, validated tool, not an internally improvised questionnaire.*

Evidence: Survey tool and administration record

2. Is the survey conducted regularly, on a defined schedule? — *A single historical survey doesn't reflect current culture.*

Evidence: Survey schedule and history

3. Are survey results reviewed and acted on, with visible follow-up? — *Measurement without action provides no real improvement.*

Evidence: Results review and action record

COMMON REASONS FOR A PARTIAL ANSWER

- **A survey is conducted but response rates are low, undermining result reliability.** — Low participation can reflect the same trust issues the survey is trying to measure.
- **Results are reviewed by leadership but not communicated back to staff.** — A closed feedback loop, invisible to staff, doesn't build

the trust genuine improvement requires.

- **Action is taken on some findings but not others, without a clear rationale communicated.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the current survey tool for validation and the administration schedule for regularity.
Week 2	If response rates are low, investigate why and address barriers to participation.
Week 3	Establish a process to communicate results and planned actions back to staff.
Ongoing	Track whether survey-driven actions are visible and completed, and repeat on schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Survey tool and history review	Reviews the survey tool used for validation and checks the administration schedule for regularity.
DOCUMENT	Results and action review	Reviews survey results and checks for evidence of genuine follow-up action, not just data collection.
ASK	Staff perception interview	Asks staff whether they believe survey results actually lead to visible change.

SUPERVISOR TIPS

- **Ask staff directly whether they believe the survey leads to real change.** — Staff perception of genuine impact is the real test, not survey administration alone.
- **Check response rates, not just that a survey was sent.** — Low participation can itself be a safety culture signal worth investigating.

EVIDENCE BASE

Safety culture surveys are a recognised patient safety measurement practice specifically because staff silence is an ambiguous signal that can indicate either genuine safety or suppressed concern, and only direct measurement distinguishes between them.

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

7.11 Patient Experience Is Measured Continuously, Not Only After Discharge CORE

Patient experience is measured through structured, ongoing feedback during the course of care — not only through the post-discharge complaint channel required elsewhere in this document, which by definition only captures concerns raised after the fact.

In plain terms: Patient experience is measured during the stay — not only after discharge or through complaints — so problems can be fixed while the patient is still there.

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

WHY THIS MATTERS

A complaint after discharge tells you what went wrong last month. A question at the bedside on day two tells you what is going wrong now — and lets you fix it for this patient. Continuous measurement — a short daily question, a mid-stay check, a real-time feedback point — catches the cold food, the unanswered call bell, the doctor who did not explain. It also changes staff behaviour: when patients are asked every day whether they were treated with respect, staff treat them with respect. The post-discharge survey remains useful, but as one source among several, not the only one.

WHAT GOOD LOOKS LIKE

- Structured feedback is collected systematically during the stay, not only after discharge.
- Collection reaches a broad, representative

COMMON FAILURE MODES

- No feedback mechanism exists beyond the post-discharge complaint channel.
- Feedback relies entirely on patients who happen to

sample of patients, not just self-selected volunteers.

- Real examples exist of improvements made in response to collected feedback.

volunteer it, unsystematically.

- Feedback is collected but no evidence exists it has ever informed a real change.

WORKED EXAMPLE

IN PRACTICE

A 130-bed hospital with a post-discharge survey returned by 8% of patients.

BEFORE

The only measure was a paper survey mailed after discharge, low response, results reviewed annually. No one asked patients during the stay. The Coordinator interviewed 20 inpatients: 12 had a concern they had not raised because 'no one asked.'

ACTION

A three-question bedside check was introduced on day two and every three days after: 'Are you being treated with respect? Do you understand your care? Is there anything we can do better today?' Done by the ward manager or a volunteer, recorded, and any concern actioned same day. A tablet at the ward exit offered a two-minute feedback form. Results by ward were reported monthly.

AFTER

The Monitor reviewed three months of bedside check data with same-day actions logged. Interviewed five inpatients: all had been asked about their experience within the last three days. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask ten inpatients today: 'Is there anything we could be doing better?' Note what you hear.
2. Introduce a three-question check on day two of every stay.
3. Record the answers and act on concerns the same day.

4. Report results by ward monthly.

The most common mistake: Relying on a post-discharge survey with a low response rate as the only measure of patient experience.

SELF-ASSESSMENT QUESTIONS

1. Is patient experience measured through structured feedback during the stay, not only after discharge? — *Real-time or near-real-time feedback, distinct from the post-discharge complaint channel.*

Evidence: Ongoing experience measurement tool

2. Is feedback collected broadly, not only from patients who happen to volunteer it? — *A systematic approach, not reliance on the small subset of patients naturally inclined to give feedback.*

Evidence: Feedback collection method

3. Is collected feedback actually reviewed and used to inform real improvements? — *Genuine responsiveness, not data collected and left unexamined.*

Evidence: Feedback review and action record

COMMON REASONS FOR A PARTIAL ANSWER

- **Feedback is collected but response rates are low, limiting how representative the picture actually is.** — Low participation can mean the loudest or most engaged voices dominate, not a representative signal.
- **Feedback is reviewed by leadership but rarely translated into a visible, communicated change.** — A closed feedback loop that doesn't visibly act on input can erode patient willingness to participate over time.
- **Collection happens for inpatient stays but not for shorter outpatient or day-procedure visits.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current patient experience measurement, if any, for systematic reach versus self-selected feedback.
Week 2	Establish or strengthen a structured, ongoing feedback mechanism during the stay.

When	What
Week 3	Build a defined review process ensuring feedback actually informs improvement decisions.
Ongoing	Track response rates and periodically communicate real changes made in response to feedback.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Measurement tool review	Reviews the ongoing patient experience measurement tool and collection method for genuine, systematic reach.
DOCUMENT	Response rate check	Reviews response rates and collection consistency, not reliance on self-selected volunteer feedback alone.
ASK	Feedback action interview	Asks staff for a specific example of a real improvement made in response to collected experience feedback.

SUPERVISOR TIPS

- **Ask for a specific, real example of a change made from feedback.** — A real example reveals genuine responsiveness better than a description of the collection process.
- **Check response rates, not just that a feedback mechanism exists.** — Low participation can undermine how representative the collected picture actually is.

EVIDENCE BASE

Ongoing patient experience measurement, distinct from post-discharge complaint mechanisms, is an established quality improvement practice in international hospital accreditation frameworks, providing earlier and more representative signal than complaint-based feedback alone.

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7.12 A Real Ethics Consultation Process Exists

CORE

Staff facing a genuine ethical dilemma in patient care have access to a real, usable ethics consultation process — a committee, a named resource, or an external arrangement — not left to resolve difficult cases alone or through informal corridor conversations.

In plain terms: When staff face a genuine ethical dilemma — withdrawing treatment, a patient refusing life-saving care, a family in conflict — there is someone they can actually consult.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

Should we continue ventilating a patient with no prospect of recovery when the family insists? Can we override a competent patient's refusal of a blood transfusion? What do we do when parents disagree about their child's treatment? These are not clinical questions and they are not legal questions; they are ethical ones, and clinicians facing them alone at 2am make worse decisions than clinicians with somewhere to turn. An ethics consultation process — a committee, a trained individual, an external advisor — gives staff a structured way to think through the dilemma. It does not need to be elaborate; it needs to exist and be reachable.

WHAT GOOD LOOKS LIKE

- A real, structured ethics consultation resource exists and is accessible.
- Staff can describe specifically and confidently how they would access it.
- Real usage exists, or a credible explanation for

COMMON FAILURE MODES

- No real consultation resource exists beyond a general policy statement about ethical principles.
- Staff are unaware of how to access any such resource.
- The process, if it exists, has never been used and nobody can explain why.

why the need hasn't yet arisen.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital with an ICU and no ethics resource.

BEFORE

Ethical dilemmas were resolved by whoever was most senior. An ICU nurse described a case where a patient's daughter demanded continued ventilation the team believed was futile; the consultant decided alone, the team was divided, and the nurse said 'I still don't know if we did the right thing.' There was no forum for the discussion.

ACTION

A small ethics consultation group was formed: a senior physician, a senior nurse, a chaplain, and an external ethicist from the university, available by phone within 24 hours. A one-page process described how to request a consultation and what to expect. Consultations were documented in the patient record. The group met quarterly to review cases and learn.

AFTER

The Monitor reviewed the process, the contact list, and records of four consultations in six months. Interviewed the ICU nurse who described using the process and feeling supported. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three senior clinicians about the last ethical dilemma they faced and who they consulted.
2. Identify three or four people who could form a consultation group.
3. Write a one-page process: how to request, response time, documentation.
4. Tell all clinical staff it exists.

The most common mistake: Assuming ethical dilemmas are resolved by seniority — the senior person is as uncertain as everyone else, just more alone.

SELF-ASSESSMENT QUESTIONS

1. Is there a real, accessible ethics consultation process — committee, named resource, or external arrangement? — *An actual, usable resource, not a theoretical statement that ethical principles matter.*
Evidence: Ethics consultation process description

2. Do staff know how to access it, not just that it exists somewhere in policy? — *Practical, known accessibility — staff can describe how they'd actually use it.*
Evidence: N/A — tested directly

3. Has the process actually been used for a real case, or does it exist only theoretically? — *Genuine use is the real test of whether this is a functioning resource or a document nobody has needed to open.*
Evidence: Usage record, or honest absence of one

COMMON REASONS FOR A PARTIAL ANSWER

- **A resource exists but is only accessible during business hours, leaving urgent after-hours dilemmas unsupported.** — Ethical dilemmas don't confine themselves to convenient hours, and a resource that assumes they will has a real coverage gap.
- **Senior staff know how to access consultation; junior staff facing the same dilemmas often don't.** — Awareness concentrated at senior levels doesn't help staff who most need support in the moment.
- **A committee exists on paper but hasn't convened or been consulted in a very long time.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current access to ethics consultation, if any, for real structure versus policy statement.
Week 2	Establish or reinforce a genuinely accessible process, including after-hours coverage.
Week 3	Brief all clinical staff, not only senior staff, on how to access it.

When	What
Ongoing	Review whether the process is genuinely being used when needed, not just theoretically available.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Process existence and structure review	Reviews the ethics consultation process for a real, defined structure, not just a policy statement of principles.
ASK	Staff access interview	Asks clinical staff how they would actually access ethics consultation for a difficult case.
DOCUMENT	Usage history check	Checks for any real, documented instance of the process being used, or an honest account of why it hasn't been.

SUPERVISOR TIPS

- **Ask a junior staff member how they'd access ethics support, not a department head.** — This reveals whether awareness genuinely reaches the staff most likely to face difficult cases directly.
- **Ask about after-hours access specifically.** — A resource available only during business hours has a real, common gap worth checking directly.

EVIDENCE BASE

Access to clinical ethics consultation is an established structural requirement in major international hospital accreditation and governance frameworks, recognising that individual clinicians should not be left to resolve genuine ethical complexity without institutional support.

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7.13 Patients and Families Have a Real Voice in Governance CORE

At least one patient or family representative has a genuine, structured role in quality review or governance discussions — not a governance and quality structure that is entirely staff and board-facing, with patient input arriving only indirectly through complaints or surveys.

In plain terms: At least one patient or family representative sits in quality or governance meetings with a real role — not a token seat with no voice.

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

WHY THIS MATTERS

Clinicians and managers see the hospital from inside. A patient sees it from the bed, the waiting room, the car park. Every quality committee that has added a patient representative reports the same thing: they raise issues nobody on the inside had noticed. The representative must be genuine: attending regularly, receiving the same papers, able to put items on the agenda, and listened to. A name on the membership list who is never invited, or who is present but silent because the meeting is in jargon, does not meet the standard.

WHAT GOOD LOOKS LIKE

- A patient or family representative holds a genuine, structured role in quality review or governance.
- The representative genuinely participates in discussion, not just attends.
- A specific, real example exists of their input shaping an actual decision.

COMMON FAILURE MODES

- No structured patient or family role exists beyond survey and complaint data reaching staff indirectly.
- A representative attends but does not genuinely participate in discussion.
- No example exists of patient or family input ever shaping a real decision.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital whose quality committee was entirely clinical and management staff.

BEFORE

No patient voice in any governance structure. The quality committee discussed patient experience data without any patient present. When asked, the chair said 'we hadn't thought about it' and worried a patient 'wouldn't understand the clinical issues.'

ACTION

Two patient representatives were recruited — one from a recent discharge, one from a community group — with a one-hour orientation. They joined the quality committee with full papers and agenda rights. The chair was asked to explain jargon. Their first meeting raised the issue of night-time noise on wards, which nobody had discussed; a noise-reduction action followed.

AFTER

The Monitor reviewed minutes of four meetings showing the representatives present and contributing, including two agenda items they raised. Interviewed one representative who described being heard. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Look at your quality committee membership. Is there a patient?
2. Recruit two — a recent patient and a community member.
3. Give them the same papers and agenda rights as everyone else.
4. Ask the chair to explain jargon and invite their view on every item.

The most common mistake: Appointing a patient representative and then never sending them the papers or inviting them to speak.

SELF-ASSESSMENT QUESTIONS

1. Does at least one patient or family representative have a genuine, structured role in quality review or governance discussions? — *An actual seat or defined role, not indirect input filtered through staff-collected feedback alone.*

Evidence: Governance or quality committee structure showing patient/family role

2. Is this representative genuinely included in discussion, not present only as an observer? — *Real participation, not token attendance without a voice in the discussion.*

Evidence: N/A — tested directly

3. Can the facility point to a specific instance where patient or family input shaped a real decision? — *Concrete evidence of influence, not just presence.*

Evidence: Example of patient/family input shaping a decision

COMMON REASONS FOR A PARTIAL ANSWER

- **A representative role exists but the position has been vacant for some time without being filled.** — A defined role that isn't actually occupied provides no real, current voice.
- **The representative attends but discussions move quickly in technical or clinical language that limits genuine participation.** — Presence without genuine accessibility to the discussion doesn't provide real influence.
- **Patient input shapes minor operational decisions but rarely reaches larger strategic or safety discussions.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current governance and quality review structure for any existing patient or family voice.
Week 2	Recruit or confirm a patient or family representative for a genuine, structured role.
Week 3	Brief the representative and the governance team on genuine participation expectations, not passive attendance.
Ongoing	Track and document specific instances where patient or family input has shaped decisions.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Governance structure review	Reviews the governance and quality review structure for a genuine, defined patient or family representative role.
OBSERVE	Meeting participation check	Where possible, observes or reviews minutes of a governance or quality meeting for genuine representative participation, not passive attendance.
ASK	Influence example interview	Asks staff and the representative, if available, for a specific example of patient or family input shaping a real decision.

SUPERVISOR TIPS

- **Ask for a specific, real example of influence, not a description of the role's existence.** — A concrete instance reveals whether this is genuine participation or a symbolic seat.
- **Check whether the role is currently filled, not just defined in principle.** — A vacant position provides no real, current voice regardless of how it's written into governance structure.

EVIDENCE BASE

Patient and family engagement in governance and quality structures, distinct from feedback mechanisms alone, is an established element of patient-centred care frameworks in international hospital accreditation and governance literature.

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ASF STANDARDS · HOSPITAL · STANDARD 8

Standard 8 — Medical Tourism

10 criteria · 8 non-negotiable · 2 core · Version 3.0

CRITERIA IN THIS STANDARD

- 8.1 — Pricing Transparency for International Patients
- 8.2 — Remote Records Transfer to Home-Country Physician
- 8.3 — Language Access for Foreign Patients
- 8.4 — Travel, Accommodation, and Logistics Coordination
- 8.5 — Post-Return Complication Tracking
- 8.6 — Visa and Embassy Support Documentation
- 8.7 — International Patient Complaint and Redress Process
- 8.8 — Facilitator and Agent Verification
- 8.9 — Travel-Associated Infection Risk Protocol
- 8.10 — Post-Procedure Travel Timing and Venous Thromboembolism Risk

8.1 Pricing Transparency for International Patients

NON-NEGOTIABLE

International patients receive a complete, written, all-inclusive cost estimate before travel is booked — covering the procedure, hospital stay, and commonly needed extras

— not a partial quote that grows once the patient has already committed to travelling.

In plain terms: International patients get a complete written cost estimate before they book travel — procedure, stay, and the extras that usually come up — with nothing hidden.

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

WHY THIS MATTERS

A patient who flies 3,000 km for surgery has no way to walk away when the bill is double the quote. They have spent on flights and hotels; they are far from home; they may be already admitted. Cost surprises for international patients are not only a complaint risk — they are a reputational catastrophe that spreads through the facilitator networks that bring patients. An all-inclusive estimate — procedure, anaesthesia, ward stay, standard medications, standard follow-up — with clearly stated exclusions and the conditions that could change it, is the basis of trust. It should be given in writing, in a language the patient reads, before they commit to travel.

WHAT GOOD LOOKS LIKE

- A complete, itemised estimate is provided before travel is booked, every time.
- Estimates include common extras, not just the base procedure.
- Patients confirm final costs matched estimates, or differences were clearly explained in advance.

COMMON FAILURE MODES

- Estimates are partial, covering only the base procedure with extras added later.
- Patients report being surprised by costs only disclosed after arrival.
- No estimate exists in writing before the patient has already committed to travel.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital receiving 200 international patients a year for orthopaedic and cosmetic surgery.

BEFORE	Estimates were given verbally by the international patient office and covered the surgeon's fee only. Patients arrived and were charged separately for anaesthesia, implants, extra nights, and medications. Complaints from international patients were three times the rate of domestic ones; two negative reviews on a facilitator's site cited 'hidden costs.'
ACTION	A standard estimate template was created per procedure: surgeon, anaesthesia, implants, expected stay, standard medications, one follow-up — total; plus a stated list of what is excluded and what circumstances could increase the cost. It is emailed in the patient's language before booking, with a signature line. Any charge outside the estimate requires the patient's written agreement.
AFTER	The Monitor reviewed 15 international patient files: all had signed estimates matching final invoices within stated exclusions. International patient complaints down 70%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten international patient files and compare the estimate given to the final bill.
2. Build an all-inclusive estimate template per common procedure, with stated exclusions.
3. Email it before booking, in the patient's language, with a signature.
4. Require written patient agreement for any charge outside the estimate.

The most common mistake: Quoting the surgeon's fee and treating everything else as 'extras' the patient should have expected.

SELF-ASSESSMENT QUESTIONS

1. Is a complete, written cost estimate provided before the patient books travel? — *Before travel is booked, not after arrival — the point*

where the patient still has a real choice.

Evidence: Written estimate, dated before booking

2. Does the estimate cover commonly needed extras, not just the base procedure? — *Anaesthesia, extended stay, common complications — the items that turn a quoted price into a real surprise.*

Evidence: Estimate itemisation

3. Can a recent international patient confirm the final cost matched the estimate, or that any difference was clearly explained in advance? — *Tests whether the estimate was honest, not just early.*

Evidence: N/A — tested directly, or via patient correspondence sample

COMMON REASONS FOR A PARTIAL ANSWER

- **Estimates are complete for standard cases but not consistently updated for complex ones.** — A patient with a more complex case is exactly the one most likely to face unanticipated costs.
- **The estimate is accurate but delivered verbally, with no written record the patient can review at home before deciding.** — A spoken estimate is harder for a patient to review carefully or share with someone helping them decide.
- **Extras are itemised for the procedure but not for potential complications.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent international patient files for estimate timing and completeness.
Week 2	Build a standard, itemised estimate template covering common extras and complications.
Week 3	Establish estimate delivery as a required step before any travel booking confirmation.
Ongoing	Contact a sample of recent patients to confirm estimate accuracy.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Estimate timing and completeness review	Reviews a sample of international patient files for a complete, itemised estimate dated before travel booking.

Method	What	Detail
ASK	Patient cost experience interview	Contacts a recent international patient to confirm whether the final cost matched what was estimated, and whether any difference was explained.
DOCUMENT	Itemisation check	Checks whether estimates include commonly needed extras, not just the headline procedure cost.

SUPERVISOR TIPS

- **Ask for the dated estimate, not a description of the pricing process.** — A dated document is the only real evidence timing requirements were met.
- **Contact a patient directly if possible.** — Patient-side confirmation reveals whether the process actually protected them, not just whether a document exists.

EVIDENCE BASE

[38] WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force when the patient has limited ability to seek a second opinion or negotiate after arrival.

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8.2 Remote Records Transfer to Home-Country Physician

NON-NEGOTIABLE

A complete, usable record of the care provided is transferred to the patient's home-country physician, in a format that physician can actually use — not a discharge summary that stays in the treating facility's own system.

In plain terms: When an international patient goes home, their own doctor receives a complete, usable record of what was done — not a one-line discharge note.

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

WHY THIS MATTERS

The patient's home-country physician will manage the recovery, the complications, and the follow-up — often for years. If all they receive is 'total hip replacement, uneventful,' they do not know the implant type, the antibiotic given, the anticoagulation plan, or what to watch for. A complication then becomes a mystery. A usable record means: operation note, implant details, medications on discharge with duration, follow-up plan, warning signs, and how to contact the operating surgeon — in a language the home physician reads, sent directly or given to the patient in a sealed form.

WHAT GOOD LOOKS LIKE

- Complete records are transferred directly to the home physician, confirmed received.
- Records are provided in a usable language and format, not just the treating facility's internal export.
- The process is consistent, not dependent on the patient remembering to request it.

COMMON FAILURE MODES

- Records are given only to the patient, with no direct transfer to their home physician.
- Records are transferred in a format or language the receiving physician cannot use.
- Transfer happens but receipt is never confirmed.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital performing joint replacements for patients from three neighbouring countries.

BEFORE

Patients left with a one-page discharge summary in the local language. Home physicians could not read it and did not know the implant type. A

	patient with a post-operative infection was treated with the wrong antibiotic at home because the home physician did not know what had been used. The hospital learned of this only when the patient's lawyer called.
ACTION	A structured international discharge pack was created: operation note, implant sticker, medication list with duration, follow-up schedule, five warning signs, and the surgeon's direct email — translated into English and the patient's language. It is emailed to the home physician (with consent) and given to the patient in print. A read-receipt is requested.
AFTER	The Monitor reviewed 12 international discharge packs and evidence of transmission to home physicians. Interviewed a home physician by email who confirmed the pack was usable. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Look at your current international discharge summary. Could a doctor in another country manage a complication from it?
2. Add: implant details, medications with duration, follow-up plan, warning signs, surgeon contact.
3. Translate into English and the patient's language.
4. Send directly to the home physician with the patient's consent.

The most common mistake: Sending the domestic discharge summary in the local language and assuming the patient will explain it to their doctor.

SELF-ASSESSMENT QUESTIONS

1. Is a complete treatment record transferred to the patient's home-country physician, not just given to the patient to pass along? — *Direct transfer, not relying on the patient to correctly deliver and explain their own paperwork.*

Evidence: Record transfer confirmation

2. Is the record provided in a language and format the home physician can genuinely use? — *Translated where needed, not just exported in the treating facility's own internal format.*

Evidence: Record format and language sample

3. Is transfer confirmed as received, not just sent? — *A record sent into an unconfirmed inbox provides no more protection than no record at all.*

Evidence: Receipt confirmation

COMMON REASONS FOR A PARTIAL ANSWER

- **Transfer happens for major procedures but not consistently for smaller or outpatient international cases.** — Perceived significance sometimes determines follow-through discipline, though any procedure can carry post-return risk.
- **Records are sent but in the treating facility's own template, not adapted for external use.** — Data can be technically present while still being genuinely hard for an outside physician to interpret quickly.
- **Transfer happens promptly for patients with an easily identified home physician, less reliably otherwise.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent international patient files for record transfer completeness and confirmation.
Week 2	Establish a standard transfer process and confirmed-receipt requirement.
Week 3	Build translation or reformatting capacity for records going to non-native-language physicians.
Ongoing	Audit transfer completeness periodically across all international patient discharges.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Transfer completeness review	Reviews a sample of international patient files for evidence of direct, complete record transfer to a home physician.

Method	What	Detail
DOCUMENT	Format and language check	Checks whether transferred records are in a language and format usable by the receiving physician.
OBSERVE	Receipt confirmation check	Verifies whether transfer includes confirmation of receipt, not just transmission.

SUPERVISOR TIPS

- **Ask for confirmed receipt, not just a sent record.** — Confirmation is the only real evidence the information reached someone who could act on it.
- **Check a case where the home physician wasn't easily identified at discharge.** — This is where the process is most likely to break down.

EVIDENCE BASE

Continuity of care across international transitions is identified in cross-border healthcare literature as a distinct risk point, with incomplete or inaccessible record transfer directly linked to preventable post-return complications.

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8.3 Language Access for Foreign Patients

NON-NEGOTIABLE

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

In plain terms: Foreign patients have a competent interpreter — not a family member or a staff member who 'speaks a bit' — for consent, treatment decisions, and

discharge.

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

WHY THIS MATTERS

Consent obtained through a relative who softens the bad news is not consent. Discharge instructions given through a porter who speaks 'some English' are instructions half-understood. The moments that require an interpreter are exactly the moments when misunderstanding causes harm: what the surgery involves, what could go wrong, what to do at home. A competent interpreter — professional, or a trained bilingual staff member with a defined role — is a patient safety requirement, not a courtesy. Using children to interpret for parents is prohibited: it is unsafe and it burdens the child.

WHAT GOOD LOOKS LIKE

- Competent interpreters are consistently engaged for consent and major treatment discussions.
- Discharge instructions are specifically covered through proper language access, not simplified informally.
- The facility can name its actual language coverage and has a real protocol for gaps.

COMMON FAILURE MODES

- Language support relies on whichever staff member happens to speak some of the patient's language.
- Discharge instructions are given without adequate language support, relying on patient comprehension alone.
- No specific plan exists for languages outside the facility's usual coverage.

WORKED EXAMPLE

IN PRACTICE

A 160-bed hospital treating patients from six language groups.

BEFORE	Interpretation was ad hoc — a family member, a nurse who spoke the language, occasionally a phone app. The Coordinator observed a consent conversation for a hysterectomy interpreted by the patient's teenage son. A post-operative patient was readmitted after misunderstanding discharge instructions interpreted by a cleaner.
ACTION	The hospital contracted a telephone interpretation service covering 40 languages, available 24 hours. Four bilingual staff completed a two-day medical interpreter course and were listed with their languages. A rule was written: consent, treatment discussions, and discharge for non-native speakers require a listed interpreter or the phone service; family members may assist but not substitute; children never interpret. Interpreter use is documented.
AFTER	The Monitor reviewed 15 international patient records: interpreter documented at consent and discharge in all. Observed a phone-interpreted consultation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask how the last five non-native-speaking patients gave consent. Who interpreted?
2. Contract a phone interpretation service — cost is per minute and modest.
3. Train two to four bilingual staff as interpreters.
4. Write the rule: listed interpreter for consent and discharge; never a child.

The most common mistake: Treating a family member as an interpreter — they edit, soften, and mistranslate, and the patient's consent is compromised.

SELF-ASSESSMENT QUESTIONS

1. Is a genuinely competent interpreter — professional or trained — used for consent and major treatment discussions? — *Not whichever*

staff member happens to speak some of the language informally.

Evidence: Interpreter engagement record

2. Are discharge instructions specifically covered through proper language access, not simplified or skipped due to language barriers? — *Discharge is exactly the point where miscommunication causes the most post-return harm.*

Evidence: Discharge interpretation record

3. Can the facility name which languages it can genuinely support, and what happens when a patient's language isn't covered? — *A specific, honest answer, not a general assurance language is never a problem.*

Evidence: Language coverage list and gap protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Interpreters are used for the initial consultation but not consistently for follow-up or discharge.** — Language needs don't end after the first conversation, but discipline sometimes does.
- **Ad hoc bilingual staff are used for common languages, with real interpreters reserved for less common ones.** — Comfort with a widely spoken language can mask genuinely inadequate interpretation quality.
- **A gap protocol exists but hasn't actually been tested with a real uncommon-language patient.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent international patient files for interpreter use consistency across the full care episode.
Week 2	Establish interpreter engagement as a required step for consent, major discussions, and discharge specifically.
Week 3	Document actual language coverage and build a specific protocol for uncovered languages.
Ongoing	Review interpreter engagement records periodically, particularly at discharge.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Interpreter engagement review	Reviews records for evidence of genuine interpreter engagement, not informal ad hoc arrangements, for consent and major discussions.
ASK	Discharge interpretation check	Asks staff how discharge instructions are specifically handled for patients needing language support.
DOCUMENT	Language coverage and gap protocol review	Reviews the facility's documented language coverage and what happens when a patient's specific language isn't available.

SUPERVISOR TIPS

- **Ask specifically about discharge, not just the initial consultation.** — This is where language support most commonly and consequentially drops off.
- **Ask what happens for a language the facility doesn't usually encounter.** — A real, tested answer reveals genuine preparedness better than a general assurance.

EVIDENCE BASE

Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and clinical outcomes compared with ad hoc interpretation by untrained bilingual staff or family members.

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8.4 Travel, Accommodation, and Logistics Coordination

CORE

The facility provides or coordinates genuine support for travel and accommodation logistics around the procedure — not leaving an international patient, often recovering from

treatment, to navigate this entirely alone in an unfamiliar country.

In plain terms: The hospital helps international patients with the logistics around their treatment — arrival, accommodation, transport — rather than leaving a recovering patient in a foreign city to manage alone.

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

WHY THIS MATTERS

A patient discharged after surgery in a city where they know no one, do not speak the language, and have a flight in four days is a patient at risk. They may not find a pharmacy, may not know where to go if a wound bleeds, may take a taxi to the wrong hospital. Coordination need not mean running a travel agency; it means a named contact, a list of verified nearby accommodation, arranged transport from airport and between hotel and hospital, and clear instructions for what to do if something goes wrong before the flight home. It is part of the clinical pathway, not a hospitality extra.

WHAT GOOD LOOKS LIKE

- Accommodation is matched to actual recovery needs, not a generic list.
- Local transport is genuinely arranged or clearly explained in advance.
- A specific, reachable contact exists for logistics questions during the stay.

COMMON FAILURE MODES

- Patients are given a generic hotel list with no guidance matched to recovery needs.
- Local transport is left entirely to the patient to figure out.
- No specific contact exists; logistics questions go to a general, slow-response inquiry line.

WORKED EXAMPLE

IN PRACTICE

A 130-bed hospital where international patients arranged their own logistics.

BEFORE	Patients booked their own hotels — sometimes an hour away, sometimes with no lift for a post-operative knee patient. One arrived at 3am with no transport. One was discharged to a hostel with stairs and no one to help. The international office gave a phone number that was answered only in office hours.
ACTION	An international patient coordinator role was created: airport pick-up arranged for every patient; a list of five vetted hotels within 15 minutes, each with a lift and 24-hour reception; transport to and from the hospital; a 24-hour emergency number; a printed 'what to do if' card. Coordination was included in the estimate (8.1).
AFTER	The Monitor reviewed the coordinator's log for 20 patients: all with airport transfer, vetted accommodation, and the emergency number issued. Two emergency calls handled within the previous quarter. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask the last five international patients how they found accommodation and got to the hospital.
2. Vet five hotels near the hospital for accessibility and 24-hour reception.
3. Arrange airport transfer for every international patient.
4. Issue a 24-hour number and a 'what if' card at discharge.

The most common mistake: Treating logistics as the patient's problem — a post-operative patient in a foreign city with no support is a clinical risk.

SELF-ASSESSMENT QUESTIONS

1. Does the facility provide or coordinate genuine support for accommodation appropriate to the patient's recovery needs? — *Matched to actual recovery requirements, not a generic hotel list handed over without guidance.*
Evidence: Accommodation coordination record

2. Is local transport between accommodation and the facility genuinely arranged or clearly explained? — *Not assumed the patient will figure out local transport independently while recovering.*

Evidence: Transport arrangement record

3. Is there a named point of contact for logistics questions during the patient's stay? — *A specific person or service the patient can actually reach, not a general inquiry line.*

Evidence: Named contact record

COMMON REASONS FOR A PARTIAL ANSWER

- **Coordination is strong for the arrival and procedure but drops off during recovery.** — Attention often concentrates on the clinical event itself, less on the days immediately after.
- **A named contact exists but response times are slow in practice.** — A contact that exists on paper without responsive real service doesn't function as intended.
- **Accommodation guidance is given but doesn't account for specific procedure-related mobility needs.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent patient logistics experience through direct outreach or file review.
Week 2	Establish accommodation guidance matched to common recovery scenarios.
Week 3	Name and publicise a specific, responsive logistics contact for the full duration of the stay.
Ongoing	Follow up with patients on logistics experience as part of routine post-care contact.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Coordination record review	Reviews a sample of international patient files for evidence of genuine accommodation and transport coordination.

Method	What	Detail
ASK	Patient logistics experience interview	Contacts a recent international patient about their actual experience navigating accommodation and transport.
DOCUMENT	Named contact verification	Checks whether a specific, reachable point of contact for logistics was provided to recent patients.

SUPERVISOR TIPS

- **Contact a recent patient directly about their logistics experience.** — This reveals the gap between intended support and what patients actually experienced.
- **Test the named contact's actual responsiveness.** — A contact's existence and its real usefulness aren't always the same thing.

EVIDENCE BASE

Patient-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction and perceived safety.

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8.5 Post-Return Complication Tracking

NON-NEGOTIABLE

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

In plain terms: The hospital follows up with international patients after they go home — and actively tracks complications, including ones their home doctor finds.

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

WHY THIS MATTERS

Once the patient flies home, most hospitals never hear from them again — unless they sue. That means the hospital does not know its own complication rate for international patients, cannot learn from it, and cannot improve. A wound infection diagnosed in the home country, an implant failure at six months, a DVT on the flight home: each is data the hospital needs. Active tracking means scheduled contact at defined intervals — one week, one month, three months — by email or phone, with a simple question set, and a way for the home physician to report. It is the only way to know whether the international programme is safe.

WHAT GOOD LOOKS LIKE

- A specific, active mechanism exists to learn about post-return complications, beyond generic satisfaction calls.
- The facility actively seeks feedback from the patient's home physician where possible.
- Identified complications are tracked and reviewed as a genuine quality indicator.

COMMON FAILURE MODES

- No specific mechanism exists beyond a generic, easily ignored follow-up call.
- Feedback is sought only from the patient, never their home physician.
- No evidence exists that any post-return complication was ever tracked or reviewed.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital that had no contact with international patients after discharge.

BEFORE

The hospital reported 'no complications' in international patients because it had no way to know. A facilitator mentioned three patients from one country who had developed infections after returning home; none had been reported to the hospital. Outcome data for international surgery was entirely absent.

ACTION

A post-return follow-up protocol was set: email at day 7, day 30, and day 90 with a five-question form in the patient's language; a phone call if no response; a direct email address for home physicians to report complications. Responses were logged and reviewed monthly. Complications were entered into the same surveillance system as domestic patients.

AFTER

The Monitor reviewed six months of follow-up data: 78% response rate; 4 complications identified and reviewed, one leading to a change in discharge anticoagulation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask: what is your complication rate for international patients? If you don't know, that's the finding.
2. Set three follow-up points — 7, 30, 90 days — with a short question set.
3. Give home physicians a direct email to report problems.
4. Log every response and review monthly.

The most common mistake: Reporting zero complications in international patients because you have never asked.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, active mechanism to learn about complications discovered after a patient returns home? — *Beyond a generic satisfaction call — a real channel for the patient's home physician or the patient themselves to report a problem.*

Evidence: Post-return tracking protocol

2. Does the facility request feedback from the patient's home physician, not only the patient? — *A home physician is often better positioned to identify a genuine complication than the patient describing symptoms informally.*

Evidence: Home physician contact record

3. Are post-return complications, when identified, tracked and reviewed as a quality indicator? — *Tracking without review misses the*

chance to improve future international patient care.

Evidence: Complication tracking and review record

COMMON REASONS FOR A PARTIAL ANSWER

- **A follow-up call happens but doesn't specifically ask about complications, only general wellbeing.** — A vague check-in question misses complications a patient may not recognise as connected to their procedure.
- **Contact is attempted once and not repeated if the patient doesn't respond.** — A single unanswered call shouldn't be the end of the process, especially for higher-risk procedures.
- **Complications are noted when reported but not systematically reviewed as a pattern.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current post-return follow-up practice for specificity and actual complication-catching capacity.
Week 2	Build a specific complication-focused follow-up protocol, including outreach to home physicians where possible.
Week 3	Establish a tracking log for any post-return complication identified.
Ongoing	Review tracked complications periodically as a quality indicator feeding back into practice.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Tracking mechanism review	Reviews the post-return tracking protocol for specificity beyond a generic satisfaction call.
DOCUMENT	Home physician contact check	Checks whether the facility actively seeks feedback from the patient's home physician, not only the patient.
ASK	Complication review interview	Asks staff whether any post-return complications have been identified and how they were reviewed.

SUPERVISOR TIPS

- **Ask for the actual follow-up questions used, not a description of the general process.** — Specific, complication-focused questions reveal genuine intent to catch problems, not just check in politely.
- **Ask for any real example of a tracked post-return complication.** — A real example, or its honest absence, reveals whether this system has ever actually functioned.

EVIDENCE BASE

Post-operative complication tracking following international medical travel is identified in the medical tourism literature as a systemic gap, with most facilities lacking any mechanism to learn about complications that surface after the patient has returned home.

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

8.6 Visa and Embassy Support Documentation CORE

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

In plain terms: The hospital provides the specific paperwork international patients need for medical visas and embassies — correctly, in the right format, and on time.

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

WHY THIS MATTERS

A medical visa application needs a letter from the treating hospital stating the diagnosis, the treatment, the dates, the estimated cost, and often a guarantee of accommodation. Each embassy has its own format. A letter that is late, wrongly formatted, or missing a required

element means the patient's visa is refused and the surgery is cancelled — with the hospital having lost the case and the patient having lost weeks. This is administrative, not clinical, but it is on the critical path. A hospital serious about international patients has a template for each common embassy and a turnaround commitment.

WHAT GOOD LOOKS LIKE

- The facility maintains current, specific knowledge of documentation requirements for its main patient countries.
- Documents are provided correctly and with enough lead time for the patient's travel needs.
- A named person owns this function and can describe the process confidently.

COMMON FAILURE MODES

- Documentation requirements are handled generically without country-specific knowledge.
- Delays or errors in documentation have affected patient travel timing.
- No one is specifically responsible; the function is handled ad hoc by whoever is available.

WORKED EXAMPLE

IN PRACTICE

A 120-bed hospital receiving patients from four countries with different visa requirements.

BEFORE

Visa letters were written ad hoc by the international office when asked. Two patients had visas refused because the letter lacked the embassy's required elements. Turnaround was up to two weeks. Nobody had checked what each embassy actually required.

ACTION

The international coordinator contacted the four relevant embassies and obtained their exact requirements. A template per embassy was created. A commitment was set: visa letter within three working days of request. A checklist was used before sending. The templates were reviewed annually.

AFTER

The Monitor reviewed the four templates, the embassy requirement documents, and a log showing 30 letters issued in three months, all within three days, no refusals attributed to letter deficiencies. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the countries your international patients come from.
2. Contact each embassy and get their exact medical visa letter requirements in writing.
3. Build a template per embassy.
4. Commit to a turnaround time and track it.

The most common mistake: Writing a generic 'to whom it may concern' letter and assuming every embassy will accept it.

SELF-ASSESSMENT QUESTIONS

1. Does the facility know the specific visa and documentation requirements for the countries its patients most commonly travel from? — *Specific, current knowledge, not general awareness that visas are sometimes needed.*

Evidence: Documentation requirements reference

2. Are required documents provided correctly and promptly, avoiding delays that could affect a patient's ability to travel in time? —

Timeliness matters especially for clinically urgent cases.

Evidence: Documentation provision timing record

3. Is there a named person responsible for visa and embassy documentation support? — *Specific ownership, not a task that falls to whoever happens to have time.*

Evidence: Role assignment record

COMMON REASONS FOR A PARTIAL ANSWER

- **Requirements are well known for the most common patient countries but not for less frequent ones.** — Familiarity naturally concentrates on frequent cases, leaving less common ones under-prepared.
- **Documentation is usually accurate but timing is inconsistent under busy periods.** — Quality and timeliness don't always fail together — one can hold up while the other slips.

- **Responsibility is informally understood but not formally assigned.**

IMPLEMENTATION PLAN

When	What
Week 1	Document current visa and embassy requirements for the facility's main patient countries of origin.
Week 2	Review recent documentation timing against patient travel deadlines for any gaps.
Week 3	Formally assign ownership of this function to a named person or role.
Ongoing	Update requirements knowledge as regulations change for key countries.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Requirements knowledge check	Reviews the facility's documented knowledge of visa requirements for its most common patient countries of origin.
DOCUMENT	Timing review	Reviews recent documentation provision timing against patient travel deadlines.
ASK	Responsible person interview	Asks whoever handles this function to describe the actual process for a recent case.

SUPERVISOR TIPS

- **Ask about a less common patient country of origin, not just the most frequent one.** — Preparedness for common cases doesn't guarantee readiness for less familiar ones.
- **Check actual timing records against a real recent case.** — A specific example reveals more than a general assurance about process quality.

EVIDENCE BASE

Medical travel facilitation literature identifies documentation delays and errors as a leading cause of care-seeking delay for international patients, with downstream clinical consequences for time-sensitive conditions.

8.7 International Patient Complaint and Redress Process

NON-NEGOTIABLE

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

In plain terms: International patients can complain and seek redress from their home country — and there is evidence that such complaints are genuinely addressed.

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

WHY THIS MATTERS

A patient who flew home with a complication and a grievance is not going to fly back to file a complaint at the front desk. If the hospital's complaint process only works in person, international patients effectively have no complaint process. And a patient with no route to complaint becomes a patient who complains publicly — to the facilitator, on review sites, to their embassy. A working process means an email or web form, a response commitment, a named person, and — for disputes — a defined redress mechanism: a refund policy, a mediation route, or a stated arbitration process. The evidence required is that complaints have been received from abroad and resolved.

WHAT GOOD LOOKS LIKE

- The complaint channel is genuinely accessible remotely, in languages international patients actually use.

COMMON FAILURE MODES

- The complaint process functionally requires physical presence or local language fluency.
- Complaints receive only automated

- Sampled complaints show substantive responses addressing the actual concern.
- The process is designed with the practical reality of remote patients in mind.

acknowledgment with no substantive follow-through.

- No consideration has been given to the practical barriers facing a patient complaining from abroad.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital whose complaints process was a form at reception.

BEFORE

No international patient had ever formally complained — because there was no way to. The facilitator reported that two patients had complained to them about the hospital; the hospital had never heard about it. A review site showed three negative reviews from international patients, none of which the hospital had responded to.

ACTION

An international complaints email and web form were created, in three languages. The international coordinator was named as the responsible person with a 5-day acknowledgement and 30-day resolution commitment. A redress policy was written: what triggers a refund, how disputes are escalated, and an external mediation option through the facilitator association. Review-site comments were monitored and responded to.

AFTER

The Monitor reviewed the log: 7 complaints from abroad in six months, all acknowledged and resolved, two with partial refunds. Reviewed the redress policy. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Try to complain about your hospital from abroad. Is it possible?
2. Create an email and web form in your patients' languages.

3. Name a person and set response times.
4. Write a redress policy: when a refund applies, how disputes escalate.

The most common mistake: Reporting zero international complaints because there is no way to make one.

SELF-ASSESSMENT QUESTIONS

1. Can an international patient submit a complaint from their home country, in a language they can use? — *Genuinely reachable remotely, in a language the patient can actually communicate in.*

Evidence: Complaint channel accessibility description

2. Is there evidence international patient complaints are actually reviewed and result in a response? — *Not just receipt acknowledgment — a substantive response addressing the actual concern.*

Evidence: Complaint response record sample

3. Does the process account for the practical difficulty of an international patient providing follow-up information or documentation from abroad? — *A process designed only for local patients can create unreasonable barriers for someone no longer in the country.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A channel exists and is technically reachable remotely, but response times are far slower for international complaints.** — A process can be accessible on paper while functioning poorly in practice for the population it's meant to serve.
- **Complaints are handled well when submitted in the facility's main working language, less well otherwise.** — Language coverage for complaints often lags behind language coverage for clinical care itself.
- **The process exists but was designed around domestic patients and never specifically reviewed for international use.**

IMPLEMENTATION PLAN

When	What
Week 1	Test the complaint channel's genuine remote accessibility, including language options.
Week 2	Review recent international complaints for response substance and timing.
Week 3	Adapt the process specifically for the practical realities facing a remote, international complainant.
Ongoing	Track international complaint response times and outcomes separately from domestic ones.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Remote accessibility check	Verifies the complaint channel is genuinely usable by someone not physically present, in a language they can use.
DOCUMENT	Response record review	Reviews a sample of international patient complaints for evidence of substantive response, not just acknowledgment.
ASK	Process design interview	Asks staff how the process accounts for the practical difficulty of a patient providing information from abroad.

SUPERVISOR TIPS

- **Try to use the channel yourself as a remote, non-native-language user would.** — Direct testing reveals barriers a policy description wouldn't show.
- **Ask for a real example of an international complaint and its resolution.** — A specific case reveals whether the process functions in practice, not just on paper.

EVIDENCE BASE

Cross-border patient redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international patients face after returning home.

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8.8 Facilitator and Agent Verification

NON-NEGOTIABLE

Any third-party medical tourism facilitator or agent the facility works with is verified and held to a defined standard of conduct — not an unregulated intermediary operating without any accountability to the facility or the patient.

In plain terms: Any agent or facilitator who brings patients to the hospital is verified and bound by a written standard of conduct — not an unknown intermediary the hospital has never checked.

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

WHY THIS MATTERS

Medical tourism facilitators can be professional and ethical, or they can be unlicensed brokers who mislead patients about outcomes, charge hidden commissions, and disappear when things go wrong. The patient does not know the difference — they trust the facilitator, and through them, the hospital. If the facilitator lies about the surgeon's experience or the recovery time, the hospital wears the consequence. Verification means: legal registration, references, a signed agreement stating what they may and may not promise, a prohibition on undisclosed commissions, and the hospital's right to terminate. An unverified facilitator is a reputational liability the hospital has chosen to accept.

WHAT GOOD LOOKS LIKE

- A specific, maintained list of verified facilitators exists, with clear inclusion criteria.
- A defined conduct standard covers accurate

COMMON FAILURE MODES

- The facility accepts referrals from any agent claiming to represent patients, with no verification.

representation of cost, risk, and outcome information.

- A real process exists for addressing facilitator misrepresentation when identified.

- No specific conduct standard exists for facilitators beyond a general assumption of good faith.
- Facilitator misrepresentation, if it occurs, has no defined consequence or review process.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital working with eight facilitators across four countries.

BEFORE

Facilitators were engaged by handshake. One was found to be promising patients 'guaranteed results' and charging a 30% commission the patient did not know about. Another had no legal registration. The hospital had no written agreement with any of them and could not say what they told patients.

ACTION

A facilitator standard was written: legal registration verified; two references checked; a signed agreement covering permitted claims (no guarantees), commission disclosure to patients, data protection, and termination. All eight were reviewed; two were terminated. A patient-facing statement was added: 'If a facilitator told you something different from what this hospital told you, tell us.'

AFTER

The Monitor reviewed six facilitator files with verification evidence and signed agreements. Interviewed two international patients who confirmed commission disclosure. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every facilitator or agent who sends you patients.

2. For each: is there a written agreement? Have you verified their registration?
3. Write a one-page standard of conduct and require signature.
4. Ask international patients what the facilitator told them — and compare.

The most common mistake: Accepting patients from any source that sends them, without knowing what the patient was promised.

SELF-ASSESSMENT QUESTIONS

1. Does the facility maintain a list of verified facilitators and agents it actually works with? — *A specific, maintained list, not an open, unmonitored referral relationship with anyone claiming to be an agent.*
Evidence: Verified facilitator list

2. Is there a defined standard of conduct facilitators must meet, covering accurate representation of costs, risks, and outcomes? — *A specific, communicated standard, not an assumption that facilitators will represent things accurately on their own.*
Evidence: Facilitator conduct standard document

3. Is there a process for addressing a facilitator found to have misrepresented information to a patient? — *A defined consequence, not an unaddressed pattern of misrepresentation.*

COMMON REASONS FOR A PARTIAL ANSWER

- **A list of preferred facilitators exists but isn't actively enforced — unlisted agents still refer patients freely.** — A preference without enforcement provides limited real accountability.
- **A conduct standard exists but facilitators were never formally briefed on it.** — An unstated expectation, however reasonable, isn't the same as one actually communicated and understood.
- **Patient feedback about facilitator accuracy is heard informally but never systematically reviewed.**

IMPLEMENTATION PLAN

When	What
Week 1	Inventory current facilitator and agent relationships and assess verification status.
Week 2	Establish a specific, communicated conduct standard for facilitators.

When	What
Week 3	Build a process for reviewing and addressing facilitator misrepresentation.
Ongoing	Cross-check patient-reported facilitator accuracy against actual costs and outcomes periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Facilitator list review	Reviews the facility's verified facilitator list and the criteria used to include or exclude an agent.
DOCUMENT	Conduct standard check	Reviews the defined conduct standard facilitators are held to, checking for specificity beyond a general expectation of good faith.
ASK	Patient-facilitator experience interview	Asks a recent international patient about the accuracy of what their facilitator told them, comparing it against actual costs and outcomes.

SUPERVISOR TIPS

- **Ask for the actual facilitator list, not a general description of working relationships.** — A real, maintained list is the only evidence genuine verification is happening.
- **Ask a patient directly what their facilitator told them before arrival.** — Comparing this against actual experience reveals facilitator accuracy in a way internal records alone cannot.

EVIDENCE BASE

Medical tourism governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the treating facility itself.

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

8.9 Travel-Associated Infection Risk Protocol

NON-NEGOTIABLE

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

In plain terms: International patients are assessed for infection risks specific to where they came from and how they travelled — and screened or isolated accordingly.

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

WHY THIS MATTERS

A patient arriving from a region with endemic MDR-TB, or who spent 20 hours in transit, or who was recently in a hospital in a country with high carbapenem-resistant organism rates, carries risks the domestic admission process does not consider. Failing to screen means the patient may be placed in a shared bay, may infect other patients, and may have their own surgery complicated by an unrecognised infection. A short travel-risk assessment at admission — where from, recent hospitalisation abroad, symptoms, vaccination status — with a defined response (screening swabs, isolation pending results) is standard infection control practice for any facility receiving international patients.

WHAT GOOD LOOKS LIKE

- A specific travel-associated infection screening protocol is applied to international patients.
- Screening accounts for relevant country-specific resistance patterns.
- Screening findings translate into genuinely

COMMON FAILURE MODES

- International patients are screened identically to local patients, with no travel-specific consideration.
- Country-specific resistance risk is not considered in screening or precautions.

applied precautions.

- Screening happens but findings don't change actual precautions applied.

WORKED EXAMPLE

IN PRACTICE

A 160-bed hospital receiving patients from three regions with high antimicrobial resistance rates.

BEFORE

International patients were admitted like domestic patients. No travel history was taken. A patient from a region with high CRE prevalence was placed in a four-bed bay; CRE was later isolated from a wound and from two other patients in the bay. Infection control had no travel-risk protocol.

ACTION

A travel-risk screen was added to international admission: country of origin, hospitalisation abroad in the last 12 months, TB symptoms, recent antibiotic use. Patients from defined high-risk regions or with recent foreign hospitalisation are swabbed for MDR organisms and isolated in a single room pending results. A regional risk list is maintained by infection control and updated annually.

AFTER

The Monitor reviewed 20 international admissions: all screened; 6 isolated pending swabs, 1 positive and managed appropriately. Reviewed the risk list. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add four questions to international admission: origin, foreign hospitalisation, TB symptoms, recent antibiotics.
2. Define which answers trigger screening swabs and isolation.
3. Ensure single-room capacity for pending-result isolation.
4. Ask infection control to maintain a regional risk list.

The most common mistake: Admitting international patients through the domestic pathway with no travel history — the risk is not visible until it has spread.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific screening protocol for travel-associated infection risk applied to international patients? — *Beyond standard admission screening — specific attention to recent travel and country-of-origin risk factors.*

Evidence: Travel-associated screening protocol

2. Does screening account for country-specific resistance patterns where relevant? — *Generic screening can miss risks specific to certain regions or recent healthcare exposure abroad.*

Evidence: Resistance-pattern reference used

3. Are appropriate precautions applied based on screening results, not just documented and set aside? — *Findings that don't change practice provide no real protection.*

Evidence: Precaution implementation record

COMMON REASONS FOR A PARTIAL ANSWER

- **Screening happens but relies on patient self-report of travel and health history, without independent verification where practical.** — Self-report alone can miss risk factors a patient doesn't realise are relevant.
- **Screening is thorough at admission but not repeated if the patient's stay involves multiple procedures over time.** — Risk factors identified once should inform care throughout the stay, not just the initial encounter.
- **Precautions are applied inconsistently depending on which staff member manages the case.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current admission screening for travel-specific infection risk elements.
Week 2	Build or strengthen a specific travel-associated risk screening protocol.
Week 3	Establish a clear link between screening findings and specific, applied precautions.

When	What
Ongoing	Update country-specific resistance pattern references as guidance evolves.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Screening protocol review	Reviews the specific travel-associated infection screening protocol applied to international patients.
DOCUMENT	Resistance-pattern reference check	Checks whether screening accounts for country-specific antimicrobial resistance patterns where relevant.
OBSERVE	Precaution implementation check	Checks whether screening findings translate into actual applied precautions, not just documentation.

SUPERVISOR TIPS

- **Ask how screening findings actually change practice, not just whether screening happens.** — The link between finding and action is where this standard is most likely to be thin in practice.
- **Check whether screening is repeated for patients with multiple procedures during one stay.** — A single point-in-time screen doesn't necessarily cover a longer, multi-stage international visit.

EVIDENCE BASE

Travel-associated antimicrobial resistance and infection risk is a documented, distinct category in infection prevention literature, with international medical travel specifically identified as a transmission risk pathway requiring targeted screening protocols.

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

8.10 Post-Procedure Travel Timing and Venous Thromboembolism Risk

NON-NEGOTIABLE

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

In plain terms: Every international patient gets a specific conversation about when it is safe to fly home — and about the raised blood clot risk from surgery plus long travel.

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

WHY THIS MATTERS

A patient who has just had a hip replacement, a caesarean, or major abdominal surgery, then sits immobile in an aircraft for eight hours, has a substantially elevated risk of a blood clot in the leg that can travel to the lung and kill. This is well documented and almost entirely preventable: wait a defined period before flying, take the prescribed anticoagulant, wear compression stockings, walk during the flight. Yet many hospitals discharge international patients without mentioning it, because the flight is 'the patient's business.' It is not. A documented conversation — with the minimum wait, the prophylaxis plan, and the in-flight precautions — is the hospital's responsibility.

WHAT GOOD LOOKS LIKE

- Every international patient receives a specific, documented travel timing discussion.
- The discussion specifically names blood clot risk, not general recovery advice alone.
- Patients can explain back the specific recommended timing for their own procedure.

COMMON FAILURE MODES

- Travel timing is left to general recovery instructions without specific discussion.
- Blood clot risk is not specifically named or explained.
- Patients cannot describe any specific recommended timing.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital performing orthopaedic surgery on patients who fly home within days.

BEFORE	Flight timing was the patient's decision. Patients booked return flights before surgery, often for two days after discharge. No VTE conversation was documented. Two international patients had developed pulmonary emboli after flying home in the previous year; the hospital learned of one through a lawyer.
ACTION	A post-procedure travel protocol was written per procedure type: minimum days before flying, anticoagulation to continue through travel, compression stockings, in-flight mobility instructions. The conversation is documented in a specific discharge section and the patient signs. Patients are advised at the estimate stage (8.1) not to book return flights until the surgeon confirms.
AFTER	The Monitor reviewed 15 international discharges: all had the travel timing section completed and signed, with anticoagulation and stockings prescribed. No VTE events in the following six months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask the last five international patients how many days after surgery they flew home.
2. Write a minimum wait per procedure with your surgeons.
3. Add a travel timing section to international discharge with a signature.
4. Tell patients at booking not to fix their return flight until cleared.

The most common mistake: Treating the flight home as the patient's decision when the clot risk is a direct consequence of the surgery you performed.

SELF-ASSESSMENT QUESTIONS

1. Does every international patient receive a specific, documented discussion of safe travel timing for their specific procedure? — *A specific, procedure-appropriate discussion, not a generic travel disclaimer.*

Evidence: Travel timing discussion documentation

2. Is the discussion specific to blood clot risk from combining this procedure with air travel, not general recovery advice? — *The specific risk named directly, not folded into general aftercare instructions.*

Evidence: N/A — tested directly

3. Can the patient explain back the recommended minimum time before flying, specific to their own procedure? — *Tests genuine understanding specific to this patient, not general awareness that travel timing matters.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The discussion happens for major procedures but is abbreviated for shorter or perceived lower-risk ones.** — Even shorter procedures combined with long-haul travel carry genuine, documented risk.
- **Timing is mentioned but the specific reasoning behind it is not explained.** — Understanding why matters for a patient weighing their own travel decision against the recommendation.
- **The discussion happens but is not documented, relying on staff memory that it occurred.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for specific, documented travel timing discussion.
Week 2	Build a specific, procedure-appropriate travel timing script into pre-discharge counselling.
Week 3	Establish documentation confirming the discussion occurred for every international patient.
Ongoing	Spot-check patient understanding of their specific recommended timing.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Travel timing documentation review	Reviews records for a specific, procedure-appropriate travel timing discussion.
OBSERVE	Discussion specificity observation	Observes whether the discussion specifically names blood clot risk, not general recovery advice alone.
ASK	Patient understanding check	Asks a patient to explain back the recommended travel timing specific to their procedure.

SUPERVISOR TIPS

- **Ask an international patient directly what they were told about travel timing.** — This tests actual understanding, not just that a conversation is assumed to have occurred.
- **Check documentation for a shorter, perceived lower-risk procedure specifically.** — This is where the discussion most commonly gets abbreviated or skipped.

EVIDENCE BASE

[42] Established international travel health guidance recommends against air travel for 10-14 days following major surgery given the combined risk of surgery and air travel for blood clots, including deep vein thrombosis and pulmonary embolism.

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← **Hospital Standards — all standards**

Self-assess against these criteria →

← **Standard 7 — Governance & Management**



Standard 9 — Refugee & Migrant Health →

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ASF STANDARDS · HOSPITAL · STANDARD 9

Standard 9 — Refugee & Migrant Health

10 criteria · 8 non-negotiable · 2 core · Version 3.0

CRITERIA IN THIS STANDARD

- 9.1 — People-Centred Care Adapted to Migration and Displacement Experience
- 9.2 — Supporting Patient Agency Through Genuine Understanding of Care and the Health System
- 9.3 — Language and Communication Aids — Interpreters and Cultural Mediators
- 9.4 — Collaborative Practice Across Health and Social Services
- 9.5 — Surge Capacity for Migration-Related Demand
- 9.6 — Evidence-Informed Care for Refugee and Migrant Populations
- 9.7 — Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts
- 9.8 — Cross-Border Continuity of Care
- 9.9 — Camp-Based and Non-Camp Service Model Fit
- 9.10 — Legal Status Diversity Recognition

9.1 People-Centred Care Adapted to Migration and Displacement Experience

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

In plain terms: Care is genuinely adapted for refugee and migrant patients — recognising trauma, legal-status fears, and the barriers they face — not just delivered the same way as for everyone else.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A refugee who has crossed a border on foot, lost family, and now fears deportation does not arrive at the hospital as an ordinary patient. They may not disclose symptoms that could mark them as a burden. They may not return for follow-up because they moved or because the last clinic reported them. They may react to a physical examination with terror rooted in what was done to them before. Trauma-informed care means staff understand this, explain before touching, ask permission, avoid triggering procedures where possible, and never threaten legal consequences. It means the hospital has decided that a person's migration status does not change their right to care — and staff know it.

WHAT GOOD LOOKS LIKE

- Staff can describe specific, genuine adaptations made for patients with migration and displacement histories.
- Trauma-informed practice is evident — safety, choice, and non-judgemental listening, not

COMMON FAILURE MODES

- Care is delivered identically regardless of stated migration or displacement history.
- Staff routinely ask for detailed trauma or torture history at first contact.
- Patients without full legal documentation are turned away or deprioritised.

routine probing for detailed trauma history.

- Care access is not conditioned on legal status documentation.

WORKED EXAMPLE

IN PRACTICE

A 170-bed hospital in a city with a large refugee population.

BEFORE	Refugee patients were treated identically to others. Staff had no training on trauma or migration. The Coordinator observed a nurse insisting a woman remove her headscarf for a routine examination, and a receptionist asking for immigration documents at registration. Refugee patients reported avoiding the hospital because 'they ask questions.'
ACTION	A half-day trauma-informed care module was delivered to all patient-facing staff, developed with a refugee support NGO. A written policy stated that immigration status is not asked and does not affect care. Registration was simplified to name, date of birth, and contact. Examination consent scripts were adapted. A refugee liaison worker was engaged part-time through the NGO.
AFTER	The Monitor reviewed the policy, training records (94% of staff), and interviewed the liaison worker and two refugee patients who described feeling safe. Observed a consultation where the clinician explained each step before touching. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask refugee-serving organisations in your area what their clients say about your hospital.
2. Write one sentence: 'We do not ask immigration status and it does not affect care.' Post it.
3. Arrange trauma-informed care training with an NGO that knows the population.

4. Remove immigration document requests from registration.

The most common mistake: Believing that treating everyone 'the same' is equity — for a traumatised patient, the same treatment is a different experience.

SELF-ASSESSMENT QUESTIONS

1. Are staff trained to adapt their practice based on a patient's migration and displacement experience, not deliver identical care regardless of history? — *Genuine adaptation, not a generic cultural-awareness statement.*

Evidence: Training record on migration-adapted care

2. Is trauma-informed practice applied, including not routinely asking for detailed trauma history at initial visits? — *WHO specifically advises against probing for detailed trauma history early in care.*

Evidence: N/A — tested directly

3. Does the facility support continuity of care regardless of a patient's legal status? — *Access not conditioned on documentation the patient may not have or be able to safely provide.*

Evidence: Access policy regarding legal status

COMMON REASONS FOR A PARTIAL ANSWER

- **Staff are aware of the principle but haven't received specific training on how to apply it practically.** — General awareness doesn't reliably translate into consistent practice without concrete training.
- **Trauma-informed care is practised by some staff but not consistently across the whole team.** — Individual good practice doesn't guarantee a system-wide standard without deliberate reinforcement.
- **Legal-status access policy exists but front-line staff apply it inconsistently under uncertainty.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current intake practice for trauma-informed care and legal-status access barriers.

When	What
Week 2	Train staff specifically on adapting practice to migration and displacement experience, using the WHO Competency Standards as a reference.
Week 3	Confirm and communicate that access is not conditioned on full legal documentation.
Ongoing	Reinforce trauma-informed intake practice through periodic case review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff practice interview	Asks clinical staff how they adapt care for a patient with a known migration or displacement history.
OBSERVE	Trauma-informed practice check	Reviews intake practice for evidence that detailed trauma history isn't routinely and inappropriately probed at first contact.
DOCUMENT	Legal-status access policy review	Reviews whether access to care is genuinely not conditioned on legal status documentation.

SUPERVISOR TIPS

- **Observe an actual intake if possible, not just review the policy.**
— Trauma-informed practice shows in how questions are actually asked, not in a written statement.
- **Ask a staff member to describe a real, specific adaptation they made for a patient.** — A concrete example reveals genuine practice better than a general description of awareness.

EVIDENCE BASE

[37] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

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

9.2

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

NON-NEGOTIABLE

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

In plain terms: Refugee and migrant patients are helped to understand not just their own care but how the health system works — and you check that they actually understood.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A patient who does not know that the hospital has an outpatient department, that a referral means an appointment somewhere else, that a prescription must be filled at a pharmacy, or that emergency care is free regardless of status — that patient cannot navigate the system. Migrants often come from health systems with entirely different structures and assumptions. Explaining the system is as important as explaining the diagnosis. And explanation is not enough: teach-back, in the patient's language, is the only way to know it landed. The consequence of failure is missed follow-up, untreated conditions, and emergency presentations that could have been prevented.

WHAT GOOD LOOKS LIKE

- Teach-back genuinely verifies understanding of both the care plan and system navigation.
- Concrete, translated navigation guidance is

COMMON FAILURE MODES

- Understanding is assumed from a nod or silence, with no active verification.
- Patients leave understanding their specific treatment but not

provided, not just general encouragement.

- Plain language is used consistently, especially when working through an interpreter.

how to access the system again.

- Medical jargon is used routinely, straining both interpretation and comprehension.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital serving newly arrived migrants from several countries.

BEFORE

Migrant patients were given standard discharge information. A high proportion did not attend follow-up. When interviewed by a liaison worker, patients said they did not understand what a 'referral' was, did not know where the outpatient clinic was, and assumed all care cost money they could not pay. Some had returned to the emergency department for routine issues.

ACTION

A one-page 'How this hospital works' guide was produced in the six most common languages: what each department does, how referrals work, what is free, who to ask. It is given at registration and explained by the liaison worker or interpreter. Discharge includes a teach-back on the next step: 'Where will you go for your follow-up, and when?' Answers are recorded.

AFTER

The Monitor reviewed 15 migrant patient records with documented teach-back; follow-up attendance had risen from 40% to 72%. Interviewed two patients who described the system correctly. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five migrant patients what a 'referral' means and where the outpatient clinic is.
2. Write a one-page system guide in your most common languages.

3. Give it at registration and explain it.
4. Add teach-back on the next step at discharge.

The most common mistake: Explaining the diagnosis carefully and assuming the patient knows how to get the follow-up you have arranged.

SELF-ASSESSMENT QUESTIONS

1. Is understanding actively checked using a teach-back approach, for both the immediate care plan and how to navigate the system, not assumed from a nod? — *Asking the patient to explain both back in their own words, not just asking "do you understand?"*
Evidence: N/A — tested directly

2. Is concrete, practical guidance provided on navigating this health system specifically — appointments, referrals, emergency versus routine care? — *Real navigation guidance, not just general encouragement to seek care.*
Evidence: Navigation guidance material

3. Is information communicated in plain language, avoiding medical jargon, particularly when working through an interpreter? — *Complex terminology strains interpretation and comprehension together.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Teach-back is used for major treatment decisions but not extended to system-navigation information.** — Understanding how to actually use the system matters as much as understanding the immediate care plan.
- **System literacy support is given verbally but not reinforced with anything the patient can review later.** — Complex system information delivered once, verbally, under stress is easily forgotten.
- **Staff assume system literacy for patients who have been in the country longer, missing gaps that may still exist.**

IMPLEMENTATION PLAN

When	What
Week 1	Observe current practice for both understanding-verification and system-navigation support.

When	What
Week 2	Train staff on teach-back technique and develop translated navigation guidance.
Week 3	Brief staff to proactively cover system literacy alongside the immediate clinical matter.
Ongoing	Spot-check patient understanding of both care and system navigation periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Teach-back practice observation	Observes a consultation, or a simulated scenario, to check whether teach-back genuinely verifies understanding of both care and system navigation.
DOCUMENT	Navigation material review	Reviews any materials or guidance provided on navigating the local health system, in relevant languages.
ASK	Patient understanding check	Asks a recent refugee or migrant patient to explain back their care plan and how they would access this facility again.

SUPERVISOR TIPS

- **Observe an actual consultation if possible, watching specifically for teach-back covering both care and navigation.** — This is a practice that is easy to describe in policy and easy to skip under time pressure.
- **Ask a patient directly what they understand about accessing care again.** — This tests actual system literacy, not just satisfaction with the immediate visit.

EVIDENCE BASE

[37] WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

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9.3 Language and Communication Aids — Interpreters and Cultural Mediators

NON-NEGOTIABLE

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

In plain terms: Trained interpreters or cultural mediators are used for language-discordant consultations — never children, and family members only when there is truly no alternative.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

This is the refugee-specific counterpart of 8.3, and the stakes are higher. Refugee patients may be discussing torture, sexual violence, or mental illness — topics a family member cannot interpret and should not hear. A cultural mediator adds what an interpreter cannot: understanding of why a patient from a particular background may refuse a male examiner, may not disclose a symptom, or may interpret a question as a threat. Children must never interpret for parents: it exposes them to adult content, it distorts the information, and it places the child in an impossible position. Where the hospital serves a refugee population, interpreter and mediator access is a core service, not an extra.

WHAT GOOD LOOKS LIKE

- Trained interpreters or cultural mediators are the default for language-discordant consultations.

COMMON FAILURE MODES

- Ad hoc bilingual staff or family members are the default, with trained interpreters rarely engaged.

- Staff confirm, without hesitation, that minors are never used to interpret.
- Family-member interpretation, when it happens, is reserved for genuinely low-risk situations only.

- A minor has been used to interpret, even occasionally.
- Family members interpret for high-risk situations like informed consent or bad news.

WORKED EXAMPLE

IN PRACTICE

A 160-bed hospital serving a refugee settlement of 30,000 people.

BEFORE	Interpretation was by family members or other patients from the same language group. A ten-year-old was observed interpreting her mother's gynaecological consultation. A man was asked to interpret for a woman describing sexual violence. There was no interpreter budget and no mediator role.
ACTION	With NGO support, four cultural mediators from the main refugee language groups were recruited and trained. A phone interpretation service covered other languages. A written rule prohibited children interpreting and required same-gender interpreters for sensitive consultations. Interpreter and mediator use was documented. Staff were briefed on why family interpretation is unsafe.
AFTER	The Monitor reviewed 20 refugee patient records: interpreter or mediator documented in all language-discordant consultations. Observed a mediator-supported consultation. Interviewed a mediator who described the same-gender rule in practice. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask how the last ten refugee consultations were interpreted. Count how many used a child or a family member.
2. Write the rule today: no children; family only as a last resort and never for sensitive topics.

3. Recruit mediators from the main language groups — NGOs can help.
4. Contract a phone service for other languages.

The most common mistake: Using the patient's child to interpret because they speak the language best — the child is harmed and the information is distorted.

SELF-ASSESSMENT QUESTIONS

1. Are trained interpreters or cultural mediators engaged for language-discordant consultations? — *Not ad hoc bilingual staff or family members as the default.*

Evidence: Interpreter engagement record

2. Is a minor ever used to facilitate interpretation for a family member? — *This should never happen — a specific, absolute rule, not a judgement call.*

Evidence: N/A — tested directly

3. When a family member interprets due to genuine unavailability of a trained interpreter, is this reserved for low-risk situations only? — *Not used for informed consent, complex care, competency assessment, or bad news — situations WHO specifically flags as requiring professional language support.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Trained interpreters are used for major appointments but family members fill in for quick or informal interactions.** — Risk doesn't scale down proportionally with how brief or informal an interaction feels.
- **The no-minors rule is understood by senior staff but not consistently reinforced with newer or junior staff.** — A critical safeguard needs to be embedded in onboarding, not assumed as common knowledge.
- **Interpreter access exists during business hours but reverts to family members after hours or in emergencies.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent language-discordant consultations for interpreter engagement patterns.
Week 2	Establish or reinforce trained interpreter access, including after-hours and emergency coverage.
Week 3	Brief all staff explicitly and unambiguously that minors are never used to interpret.
Ongoing	Audit family-member interpretation instances to confirm they're confined to genuinely low-risk situations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Interpreter engagement review	Reviews records for evidence of trained interpreter or cultural mediator engagement in language-discordant consultations.
ASK	Minor-interpreter policy check	Asks staff directly whether minors are ever used to interpret, and confirms understanding that this is never acceptable.
OBSERVE	High-risk situation check	Checks whether family-member interpretation, where it occurs, is confined to genuinely low-risk situations, never consent or bad news.

SUPERVISOR TIPS

- **Ask the minor-interpreter question directly and expect an immediate, confident answer.** — Any hesitation on this specific point is a serious signal worth investigating further.
- **Check after-hours and emergency interpreter coverage specifically.** — This is where the policy is most likely to quietly lapse.

EVIDENCE BASE

[37] WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion,

and compromised confidentiality as documented risks of family-member interpretation generally.

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

9.4 Collaborative Practice Across Health and Social Services CORE

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

In plain terms: The hospital works with legal, housing, education, and social services relevant to refugee patients — because their health depends on more than what happens in the hospital.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

A refugee child with malnutrition needs food, not just a prescription. A woman with chronic pain and a pending asylum claim needs legal support to reduce the stress that worsens the pain. A man with TB living in an overcrowded shelter needs housing to complete treatment. The hospital cannot solve these problems, but it can connect patients to those who can — if it knows who they are. Collaborative practice means a directory of local services, referral pathways that actually work, and periodic contact between the hospital and those services. It is the difference between treating symptoms and addressing causes.

WHAT GOOD LOOKS LIKE

- Real, working referral relationships exist with

COMMON FAILURE MODES

- No real working relationships exist with

relevant legal, housing, and social support services.

- Handover documentation consistently includes migration- and displacement-related context.
- Staff can describe genuine, specific examples of collaborative practice across services.

social support services beyond general awareness they exist.

- Handover documentation covers clinical facts only, omitting migration-related context entirely.
- Staff cannot describe any specific instance of collaborative, cross-service practice.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital in a region hosting refugees with no established links to social services.

BEFORE

Clinicians saw refugee patients with problems rooted in housing, legal status, and food insecurity, and had no one to refer to. A child with recurrent chest infections lived in a damp shelter; the paediatrician prescribed antibiotics repeatedly. No directory of services existed; no one had met the local refugee legal aid organisation.

ACTION

The Coordinator and the refugee liaison worker mapped local services: legal aid, housing support, food assistance, education, mental health. A one-page directory was created for clinicians. A quarterly meeting with the three main NGOs was established. Referral forms were created and tracked. The child's family was referred to housing support and rehoused.

AFTER

The Monitor reviewed the directory, meeting minutes from three quarters, and 25 tracked referrals with outcomes. Interviewed an NGO partner who described the working relationship. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the non-medical problems you see in refugee patients: housing, legal, food, education.
2. Find the organisations in your area that address each. Meet them.
3. Create a one-page directory for clinicians.
4. Track referrals and meet the organisations quarterly.

The most common mistake: Treating the medical consequence of a social problem repeatedly because no one has connected the patient to the service that could fix the cause.

SELF-ASSESSMENT QUESTIONS

1. Does the facility have working relationships with relevant legal, housing, or social support services for referral? — *Actual working relationships, not just awareness that such services theoretically exist.*
Evidence: Referral relationship record
2. Does handover of care to another provider include migration- and displacement-related context, not just clinical facts? — *Cultural, language, and migration context specifically included in handover.*
Evidence: Handover documentation sample
3. Are staff from refugee or migrant backgrounds, where present, genuinely utilised for their relevant skills and insight? — *Recognising this as a specific asset, not incidental to their role.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Referral relationships exist for the most common needs but not for less frequent ones.** — Coverage naturally concentrates where demand is highest, leaving gaps elsewhere.
- **Handover includes some migration context but inconsistently, depending on which staff member completes it.** — Individual practice variation without a standard template produces uneven results.
- **Collaboration happens reactively when a crisis emerges, not proactively as part of routine care.**

IMPLEMENTATION PLAN

When	What
Week 1	Map current referral relationships with relevant social support services.
Week 2	Build or strengthen relationships with services covering common gaps.
Week 3	Standardise handover documentation to consistently include migration-related context.
Ongoing	Review collaborative practice examples periodically to confirm it remains genuine, not nominal.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Referral relationship review	Reviews evidence of actual working relationships with relevant social support services, not just theoretical awareness.
DOCUMENT	Handover content review	Reviews handover documentation for inclusion of migration- and displacement-related context, not clinical facts alone.
ASK	Collaborative practice interview	Asks staff to describe a real instance of engaging social support services for a refugee or migrant patient.

SUPERVISOR TIPS

- **Ask for a real, specific referral example, not a general description of awareness.** — A concrete instance reveals whether relationships are genuinely working, not just theoretically available.
- **Check handover documentation directly for migration-related content.** — This is a specific, checkable detail that reveals whether the practice is systematic or incidental.

EVIDENCE BASE

[37] WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

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

9.5 Surge Capacity for Migration-Related Demand

NON-NEGOTIABLE

The facility has a real, activatable plan for responding flexibly to sudden increases in demand from migration or displacement events — expansion of assessment points, treatment distribution, and focus on critical needs — not an assumption that routine capacity will simply absorb any surge.

In plain terms: The hospital has a real, tested plan for a sudden surge in patients from a migration or displacement event — where they will be assessed, who will do it, and what supplies are needed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

A border opens, a camp is evacuated, a conflict displaces a town — and 500 people arrive at the nearest hospital in 48 hours. Most need assessment, some need urgent care, many need vaccination, all need food and water. A hospital with no plan is overwhelmed and turns people away or delivers chaotic care. Surge capacity planning means: a designated assessment area that can be opened rapidly, a triage protocol for mass arrivals, a call-in list, a stockpile of the basics (rehydration, vaccines, wound care), and agreements with health authorities and NGOs about who does what. It should be tested — at least on paper — before it is needed.

WHAT GOOD LOOKS LIKE

- A specific, written surge response plan exists

COMMON FAILURE MODES

- No specific surge plan exists beyond an

covering key operational elements.

- The plan has been tested through drill or actual surge experience, with lessons incorporated.
- Staff wellbeing and burnout risk during a surge are explicitly addressed.

assumption that staff will manage.

- The plan, if it exists, has never been tested or exercised.
- Staff wellbeing during a surge is not addressed anywhere in the plan.

WORKED EXAMPLE

IN PRACTICE

A 180-bed hospital 40 km from a border that has seen two displacement events in five years.

BEFORE

The disaster plan (5.3) covered mass casualty events but not migration surges. When 300 displaced people arrived in one weekend two years earlier, the hospital had no assessment area, no interpreters, and ran out of oral rehydration solution. Staff described it as 'chaos.'

ACTION

A migration surge annex was added to the disaster plan: a covered outdoor area designated for rapid assessment; a five-minute screening protocol (acute illness, injury, pregnancy, vaccination, malnutrition); an activation trigger; a call-in list including interpreters and NGO partners; a stockpile list for 500 people for 72 hours; an agreement with the regional health authority on referral and reporting. A tabletop exercise was run with NGO partners.

AFTER

The Monitor reviewed the annex, the stockpile inventory, the health authority agreement, and the tabletop exercise report with actions. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask: if 300 people arrived this weekend, where would you assess them and who would do it?

2. Write a one-page surge annex: area, trigger, screening protocol, call-in list.
3. Stockpile the basics for 500 people for 72 hours.
4. Run a tabletop exercise with local NGOs and the health authority.

The most common mistake: Assuming the mass casualty plan covers a migration surge — a surge is hundreds of mostly well people needing assessment, not dozens of injured.

SELF-ASSESSMENT QUESTIONS

1. Does the facility have a specific, written plan for surge response to migration-related demand increases? — *A specific plan, not a general assumption that staff will manage if it happens.*

Evidence: Surge response plan document

2. Has this plan actually been tested or exercised, not just written and filed? — *An untested plan's real gaps remain unknown until an actual surge reveals them.*

Evidence: Drill or exercise record

3. Does the plan address staff wellbeing and burnout risk during a surge, not only operational capacity? — *Sustained surge response carries real staff mental health risk that a purely operational plan can miss.*

Evidence: Staff support provisions within the plan

COMMON REASONS FOR A PARTIAL ANSWER

- **An operational surge plan exists but hasn't been updated since it was first written.** — Staffing, capacity, and context all change over time, and a stale plan may not reflect current reality.
- **The plan addresses capacity expansion well but doesn't name specific triggers for activation.** — Without a clear activation threshold, a good plan can be deployed too late to be genuinely useful.
- **Staff support exists informally but isn't written into the plan itself.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the current surge plan, if one exists, for specificity and currency.
Week 2	Define clear activation triggers and update capacity expansion elements.
Week 3	Add explicit staff wellbeing and burnout-prevention provisions to the plan.
Ongoing	Exercise the plan periodically, even at small scale, to keep it genuinely actionable.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Surge plan review	Reviews the surge response plan for specificity covering assessment expansion, treatment distribution, and critical-needs focus.
DOCUMENT	Exercise record check	Checks for evidence the plan has been tested through drill or exercise, not only written.
ASK	Staff wellbeing provision interview	Asks whether the plan addresses staff support and burnout risk during a sustained surge.

SUPERVISOR TIPS

- **Ask for the activation trigger specifically, not just the plan's existence.** — A plan without a clear trigger risks being deployed too late to matter.
- **Ask how the facility has handled a real past surge, if one has occurred.** — Real experience, or its honest absence, reveals more than a hypothetical plan alone.

EVIDENCE BASE

[37] WHO Competency Standard 6 specifically requires health workers to respond flexibly and collaboratively to migration- and displacement-related surges in demand, identifying expansion of assessment points, treatment distribution, and focus on critical needs as key response elements.

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9.6

Evidence-Informed Care for Refugee and Migrant Populations

CORE

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

In plain terms: Staff use clinical guidelines specific to refugee and migrant health where they exist, know where evidence is thin, and adapt sensibly.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Refugee health has specific evidence: screening for TB, hepatitis B, and parasites by region of origin; vaccination catch-up schedules; recognition of conditions rare in the host country; management of trauma-related mental illness. Applying host-country guidelines without adaptation means missing conditions the host population does not have and over-testing for ones the refugee population does not. Where evidence exists — WHO, UNHCR, national refugee health guidelines — staff should use it. Where it does not, they should know that, and adapt with judgment rather than guess.

WHAT GOOD LOOKS LIKE

- Staff have genuine access to and use guidelines specific to refugee and migrant health where they exist.
- Staff can describe specific, relevant differences in health

COMMON FAILURE MODES

- General population guidelines are applied uncritically with no adaptation for this population's documented differences.
- Staff cannot describe any specific way refugee and migrant health needs differ

needs for conditions they commonly treat.

- A real process exists for identifying and responding to evidence gaps.

from the general population.

- No process exists for identifying where evidence for this population is genuinely lacking.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital that had started receiving refugees from a region with high hepatitis B and TB prevalence.

BEFORE

Refugee patients were assessed using standard domestic protocols. Hepatitis B screening was not routine. Two cases of active TB were diagnosed late after multiple presentations. Clinicians were unaware of the WHO and national refugee health screening recommendations.

ACTION

The Coordinator obtained the national refugee health guideline and the WHO recommendations for the relevant region. A refugee health screening protocol was written: TB screening, hepatitis B and C, HIV with consent, parasitic infection screening, vaccination status, mental health screen. Clinicians received a one-hour briefing. The guideline was reviewed annually with an infectious diseases specialist.

AFTER

The Monitor reviewed the protocol with its sources, training records, and 20 refugee patient records showing protocol-based screening. Two hepatitis B cases identified and treated. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find your national refugee health guideline, or the WHO/UNHCR one for your region.
2. Compare it to what you currently do for refugee patients.
3. Write a screening protocol based on the guideline.

4. Brief clinicians and review annually.

The most common mistake: Applying the domestic screening protocol to refugee patients from regions with a completely different disease burden.

SELF-ASSESSMENT QUESTIONS

1. Do staff have access to and use evidence-informed guidelines specific to refugee and migrant health, where they exist? — *Specific guidance, not just general clinical guidelines applied without adaptation.*

Evidence: Guideline access and reference record

2. Can staff describe how refugee and migrant health needs may differ from the general population for conditions they commonly treat? — *Genuine awareness of specific, relevant differences, not a general acknowledgment that differences might exist.*

Evidence: N/A — tested directly

3. Is there a process for identifying and responding to gaps in evidence specific to this population? — *Recognising uncertainty is itself part of good practice here, not something to paper over.*

Evidence: Evidence gap identification process

COMMON REASONS FOR A PARTIAL ANSWER

- **Awareness exists among senior clinical staff but hasn't been systematically shared with the wider team.** — Knowledge held by a few doesn't guarantee it shapes practice across the whole facility.
- **Specific guidelines are used for some conditions but general guidelines are applied uncritically for others.** — Coverage often concentrates on the most visible or common conditions, leaving others under-adapted.
- **Evidence gaps are recognised informally but never documented or fed back into practice improvement.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current guideline use for evidence-informed, population-specific content.
Week 2	Identify and distribute relevant refugee and migrant health guidelines where they exist.

When	What
Week 3	Brief staff on documented population-specific health need differences relevant to common conditions.
Ongoing	Track identified evidence gaps and revisit guidance as new evidence emerges.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Guideline access review	Checks whether staff have access to evidence-informed guidelines specific to refugee and migrant health.
ASK	Population-difference awareness interview	Asks staff to describe specific ways refugee and migrant health needs differ from the general population for conditions they commonly see.
DOCUMENT	Evidence gap process review	Reviews any process for identifying and responding to evidence gaps specific to this population.

SUPERVISOR TIPS

- **Ask about a specific, common condition, not a general question about awareness.** — Specificity reveals genuine knowledge better than a general question would.
- **Ask what happens when evidence for this population genuinely doesn't exist.** — A thoughtful answer to genuine uncertainty is itself a sign of good practice here.

EVIDENCE BASE

[37] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

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

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

NON-NEGOTIABLE

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

In plain terms: Staff actively reflect on their own biases and culture, the hospital supports this through structured practice, and staff working with traumatised patients are looked after.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Every clinician has assumptions about people from other cultures, and most are unaware of them. The nurse who assumes a refugee is exaggerating pain, the doctor who is impatient with a patient who will not make eye contact, the receptionist who is curt with someone who does not understand the form — each is acting on bias, and each affects care. Reflective practice — structured time to examine one's reactions — reduces this. The second element is staff wellbeing: hearing accounts of torture and loss every day takes a toll, and staff who are burned out become staff who withdraw. Supervision, peer support, and access to counselling are not luxuries in a hospital serving refugees.

WHAT GOOD LOOKS LIKE

- A structured reflective practice process genuinely exists and is used, not just assumed.
- Genuine, accessible psychological support and

COMMON FAILURE MODES

- No structured reflective practice process exists beyond an assumption of individual self-awareness.
- Psychological support exists only nominally, with

debrief structure exist and staff actually use them.

- Staff can describe specific, real examples of both bias adaptation and vicarious trauma awareness.

no evidence staff actually access it.

- Staff cannot describe any specific example of adapting practice or recognising vicarious trauma.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital where a third of patients are refugees.

BEFORE

No reflective practice existed. Staff complained about refugee patients in the break room; some described them as 'demanding.' A nurse who had heard multiple accounts of sexual violence had started avoiding female refugee patients. There was no supervision or support for staff exposed to trauma narratives.

ACTION

Monthly facilitated reflective practice sessions were introduced for clinical teams, led by a psychologist from a partner NGO, using real (anonymised) cases. An implicit bias workshop was run once for all staff. A peer support scheme was set up. Confidential counselling access was arranged through the NGO. Attendance was tracked.

AFTER

The Monitor reviewed session records (10 sessions, average 70% attendance), workshop records, and the counselling access agreement. Interviewed three staff who described the sessions as valuable and gave examples of changed practice. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Listen in the break room. What do staff say about refugee patients when they think no one is listening?
2. Arrange one implicit bias workshop with an NGO or university.
3. Start monthly reflective practice sessions with a facilitator.

4. Arrange confidential counselling access for staff.

The most common mistake: Training staff in cultural competence once and assuming bias is fixed — it is a practice, not a certificate.

SELF-ASSESSMENT QUESTIONS

1. Does the facility have a structured process for staff reflective practice regarding bias and cultural awareness? — *A defined process, not an assumption that staff will naturally self-reflect adequately.*
Evidence: Reflective practice process description

2. Does the facility provide genuine, accessible psychological support and a structured space to debrief difficult cases? — *Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.*
Evidence: Psychological support and debrief process record

3. Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves or colleagues? — *Genuine, concrete examples, not general statements of good intentions or awareness.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Reflective practice happens informally among some staff but is not structured or facility-wide.** — Individual good practice does not reliably generalise without a defined, shared process.
- **Support exists but staff are unaware it is available or feel discouraged from using it.** — A benefit's existence does not guarantee genuine, comfortable access to it.
- **Debriefs happen after major incidents but not as a routine practice for cumulative, everyday difficulty.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current training content and support access for genuine coverage of bias and staff wellbeing.
Week 2	Establish a structured reflective practice process and strengthen debrief structure.

When	What
Week 3	Deliver specific training on institutional discrimination and normalise use of available psychological support.
Ongoing	Revisit reflective practice and staff wellbeing periodically, using real case examples where appropriate.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Reflective practice process review	Reviews the facility's structured process, if any, for staff reflective practice on bias and cultural awareness.
DOCUMENT	Support and debrief access review	Reviews what psychological support and debrief structure genuinely exist and whether they are actually used.
ASK	Staff example interview	Asks a staff member for a specific instance of recognising and adapting for their own bias, and how they or the team handled a recent difficult case.

SUPERVISOR TIPS

- **Ask for a specific personal example, not a general statement of awareness.** — A concrete instance distinguishes genuine reflective practice from familiarity with the concept.
- **Ask staff directly whether they have used available support, not just whether it exists.** — Genuine uptake, not nominal availability, is the real test.

EVIDENCE BASE

[37] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

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9.8 Cross-Border Continuity of Care

NON-NEGOTIABLE

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

In plain terms: Refugee and migrant patients are given their own health record in a form they can carry — paper or digital — so it works wherever they go next.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A refugee may be in three countries in a year. Each hospital that treats them starts from zero: no history, no medication list, no vaccination record, no knowledge of the TB treatment started two countries ago. A portable record — a printed summary the patient keeps, a vaccination card, a QR code linking to a secure online summary — means the next clinician knows what was done. It must be in a form the patient can hold and use: a hospital number in a system the next country cannot access is not portable. The record is the patient's; the hospital's job is to give them a copy that works.

WHAT GOOD LOOKS LIKE

- Patients are consistently given a genuine, portable health record they hold themselves.
- Records are updated as care continues, not static from a single point in time.

COMMON FAILURE MODES

- No patient-held record exists beyond what stays in the facility's own internal system.
- Records are given once and never updated as care continues.

- Record content — medication, vaccination history — is genuinely useful across a border.

- Record content is too facility-specific to be genuinely useful elsewhere.

WORKED EXAMPLE

IN PRACTICE

A 160-bed hospital near a transit route used by refugees moving onward.

BEFORE

Refugees received no record on departure. The hospital's electronic system was inaccessible from anywhere else. A patient started on TB treatment moved on after two weeks with no documentation; the next hospital restarted treatment from scratch, and resistance developed. Vaccinations given were not recorded anywhere the patient could show.

ACTION

A portable health summary was created: one page in English and the patient's language — diagnoses, medications with duration, vaccinations with dates, allergies, pending results, and the hospital's contact. It is printed for every refugee patient at discharge and, where the patient has a phone, also sent as a PDF. A vaccination card is issued. The summary is explained by an interpreter.

AFTER

The Monitor reviewed 15 refugee discharges, all with portable summaries and vaccination cards. Interviewed a patient who showed the summary on her phone and explained its contents. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask a refugee patient at discharge: 'What will you show the next doctor?' If the answer is nothing, that is the gap.
2. Create a one-page portable summary template in English and your main refugee languages.
3. Print it for every refugee patient and send as PDF where possible.

4. Issue a physical vaccination card.

The most common mistake: Keeping excellent records in a system the patient will never be able to access from the next country.

SELF-ASSESSMENT QUESTIONS

1. Are patients given their own portable health record, in a form they can carry with them? — *Something the patient physically or digitally holds themselves, not only a record in the facility's internal system.*

Evidence: Patient-held record sample

2. Is the record kept updated as care continues, not given once and left static? — *An outdated record loses much of its value for continuity of care.*

Evidence: Record update practice

3. Does the record include information — medication history, vaccination record — that would be genuinely useful to a different provider in a different country? — *Content specifically useful across a border, not just internally relevant notes.*

Evidence: Record content sample

COMMON REASONS FOR A PARTIAL ANSWER

- **A patient-held record exists but isn't consistently offered to every relevant patient.** — A good practice that depends on individual staff remembering to offer it isn't yet a reliable system.
- **Records are given but patients aren't clearly told how or why to keep and use them.** — A document without explanation of its purpose is less likely to be genuinely used.
- **Updates happen for major changes but not consistently for smaller, cumulative ones.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for providing patients their own portable health records.
Week 2	Establish a standard patient-held record format and consistent offering practice.
Week 3	Brief patients clearly on the purpose and use of their own portable record.

When	What
Ongoing	Build record updates into routine care so they don't become static over time.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Patient-held record review	Reviews whether patients are provided a genuine, portable health record, and its actual content.
OBSERVE	Update practice check	Checks whether patient-held records are updated as care continues, not issued once and left static.
ASK	Patient practice interview	Asks a refugee or migrant patient whether they were given and understand how to use their own portable record.

SUPERVISOR TIPS

- **Ask a patient directly whether they have and understand their own record.** — Patient-side confirmation reveals whether this is genuinely functioning, not just policy.
- **Check record content for genuine cross-border usefulness, not just facility-internal notes.** — Content specificity is what determines whether this actually helps continuity of care elsewhere.

EVIDENCE BASE

[37] WHO's explanatory notes for Competency Standard 1 specifically identify patient-held records — paper or electronic — updated regularly, as a key strategy for improving continuity of care given the mobility of refugee and migrant populations.

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9.9 Camp-Based and Non-Camp Service Model Fit

NON-NEGOTIABLE

The facility explicitly identifies which service model it operates under — formal camp, informal urban settlement, reception or transit centre, or established resettlement context — and demonstrates its practices are genuinely fit for that specific context, not a generic approach applied uniformly regardless of setting.

In plain terms: The hospital knows exactly which refugee service model it operates in — camp, urban settlement, transit centre, established community — and has designed its services to fit that reality.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A hospital serving a formal camp with 50,000 residents faces different demands from one serving refugees dispersed in urban apartments, or a transit centre where people stay 48 hours. The camp needs outreach, mass screening, and coordination with camp health services. The urban setting needs accessibility, cultural mediation, and links to community organisations. The transit centre needs rapid assessment and portable records. A hospital that has not named its model has not thought about what its refugee population actually needs. Naming it is the first step to designing services that fit.

WHAT GOOD LOOKS LIKE

- The facility can clearly state and justify its specific service model.
- Practices are genuinely adapted to that model, not a generic template.
- There's real awareness of how the facility would adapt if its context shifted.

COMMON FAILURE MODES

- The facility cannot articulate which service model it actually operates under.
- Practices are generic, apparently copied from an unrelated context, without adaptation.
- No consideration has been given to what would change if the population or context shifted.

WORKED EXAMPLE

IN PRACTICE

A 140-bed hospital 15 km from a formal refugee camp and also serving refugees living in the nearby city.

BEFORE	The hospital treated refugee patients as they arrived, with no distinction between camp residents and urban refugees. Camp residents often could not reach the hospital; urban refugees did not know it existed. No one had asked what each group actually needed. Services were the same for both.
ACTION	The Coordinator worked with the camp management agency and an urban refugee NGO to map both populations. The hospital documented its dual model. For the camp: a weekly outreach clinic and a transport arrangement for referrals. For urban refugees: a cultural mediator, multilingual signage, and a partnership with the NGO for outreach. Different pathways were written for each.
AFTER	The Monitor reviewed the service model document, the outreach clinic records, the transport log, and the NGO partnership agreement. Interviewed the camp health coordinator who described the working relationship. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Write one sentence: 'The refugees we serve live in [camp / urban / transit / established community].'
2. For each setting you serve, ask the relevant agency what those refugees need from a hospital.
3. Design one pathway per setting.
4. Document it and share with partners.

The most common mistake: Delivering one undifferentiated service to refugee populations whose circumstances and needs

are entirely different.

SELF-ASSESSMENT QUESTIONS

1. Can the facility clearly state which service model it operates under, and why that classification fits its actual context? — *A specific, considered answer, not an assumption that one generic approach applies everywhere.*

Evidence: Service model self-classification

2. Are the facility's specific practices — staffing, scheduling, outreach — genuinely adapted to that model, not copied from a different context? — *Real adaptation, not a generic template applied regardless of actual setting.*

Evidence: Model-specific practice adaptation record

3. Has the facility considered what changes if its population or context shifts between models over time? — *Genuine preparedness for a changing situation, not an assumption the current model is permanent.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The model is understood by leadership but not reflected consistently in front-line practice.** — Strategic awareness doesn't automatically translate into operational adaptation without deliberate effort.
- **Practices are well adapted for the primary population served but not for a secondary group also present.** — Facilities serving mixed populations can default to their majority context and under-serve others.
- **The classification was accurate when first made but hasn't been revisited as the context evolved.**

IMPLEMENTATION PLAN

When	What
Week 1	Have leadership explicitly classify and document the facility's actual service model.
Week 2	Review current practices for genuine fit against that specific model.
Week 3	Adjust any practices found to be generically applied rather than context-adapted.

When	What
Ongoing	Revisit the model classification periodically as population or context may shift.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Model self-classification interview	Asks facility leadership to state and justify which service model the facility actually operates under.
DOCUMENT	Practice adaptation review	Reviews whether specific practices are genuinely adapted to the stated model, not generically applied.
ASK	Context-shift preparedness interview	Asks how the facility would adapt if its population or operating context shifted between models.

SUPERVISOR TIPS

- **Ask the classification question directly and expect a specific, considered answer.** — Hesitation or vagueness here often signals the facility hasn't genuinely thought through its own context.
- **Check for evidence of real adaptation, not just a template with the local name inserted.** — Superficial customisation can look like adaptation without functioning as it.

EVIDENCE BASE

[37] WHO's multicountry review underpinning the Global Competency Standards identified four broad models of care for refugee and migrant populations — mainstream, specialised-focus, gateway, and limited/external-actor — and found that service delivery approaches vary meaningfully across them.

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9.10 Legal Status Diversity Recognition

NON-NEGOTIABLE

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

In plain terms: The hospital can name which legal status groups it serves — asylum seekers, recognised refugees, stateless people, internally displaced, undocumented — and knows what each group is entitled to.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

An asylum seeker in many countries is entitled to emergency care only. A recognised refugee has the same entitlements as citizens. A stateless person may have no entitlement at all under the letter of the law. An undocumented migrant may be entitled to nothing — or to everything, depending on the jurisdiction and the type of care. A hospital that does not know these distinctions either turns away people who are entitled to care or treats people it cannot be reimbursed for without knowing it. Knowing the categories, the entitlements, and — critically — the hospital's own policy on treating people regardless of entitlement is the foundation for consistent, fair, and legally defensible practice.

WHAT GOOD LOOKS LIKE

- Staff can specifically name and describe the legal status categories among patients they serve.
- Access policy genuinely differentiates by status where legally relevant, not applied uniformly.

COMMON FAILURE MODES

- Staff cannot distinguish between different legal status categories among their own patient population.
- A single, uniform assumption about access rights is applied

- Staff demonstrate specific awareness of vulnerabilities linked to particular legal statuses.

- regardless of actual legal status.
- No awareness exists of status-specific vulnerabilities, such as those facing stateless persons.

WORKED EXAMPLE

IN PRACTICE

A 150-bed hospital in a country with five legal categories for displaced people and different entitlements for each.

BEFORE

Registration staff did not know the categories. Patients were sometimes turned away because 'refugees are not covered' when in fact they were. Others were treated and the hospital could not claim reimbursement because the correct category was not recorded. The hospital had no written position on treating people outside any entitlement.

ACTION

The Coordinator obtained the legal entitlements for each category from the Ministry and UNHCR. A one-page reference was created for registration staff. A hospital policy stated: emergency care for everyone regardless of status; other care per entitlement; and a defined charity fund for those with no entitlement. Registration records the category (with the patient's consent) for reimbursement purposes only — it does not affect clinical care.

AFTER

The Monitor reviewed the entitlement reference, the policy, and 20 registration records with category correctly recorded. Interviewed two registration staff who correctly described entitlements for three categories. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the legal status categories that exist in your country for displaced people.

2. Find out what each is entitled to — ask the Ministry or UNHCR.
3. Write a one-page reference for registration staff.
4. Decide and write down what you will do for people with no entitlement.

The most common mistake: Treating all displaced people as one category — 'refugees' — when the law treats them differently and the hospital's obligations differ.

SELF-ASSESSMENT QUESTIONS

1. Can staff name the different legal status categories among the patients this facility actually serves? — *Specific awareness of asylum seeker, refugee, stateless, and internally displaced distinctions relevant to this context.*

Evidence: Staff knowledge of legal status categories served

2. Does the facility apply a single, uniform assumption about access rights, or does it recognise genuine differences by status? — *Genuine differentiation where it legally matters, not a one-size-fits-all approach.*

Evidence: Access policy by legal status category

3. Are staff aware of the particular vulnerabilities that can attach to a specific legal status, such as statelessness? — *Specific, not generic, awareness of status-linked risk.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Awareness exists for the most common status category served but not for less frequent ones.** — Familiarity naturally concentrates on the majority population, leaving smaller groups under-recognised.
- **Access policy differentiates on paper but front-line staff apply it inconsistently in practice.** — A correct written policy still needs active reinforcement to hold under real, ambiguous cases.
- **General awareness of legal status differences exists without specific knowledge of this context's relevant distinctions.**

IMPLEMENTATION PLAN

When	What
Week 1	Identify which legal status categories are actually present among the facility's patient population.
Week 2	Review and correct access policy to genuinely differentiate by status where legally relevant.
Week 3	Brief staff specifically on status-linked vulnerabilities relevant to this population.
Ongoing	Revisit legal status awareness as the facility's population composition may shift over time.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Legal status awareness interview	Asks staff to name and describe the legal status categories among patients they actually serve.
DOCUMENT	Access policy review	Reviews whether access policy genuinely differentiates by legal status category where legally relevant, rather than applying one assumption uniformly.
ASK	Status-specific vulnerability interview	Asks staff about specific vulnerabilities linked to a particular legal status relevant to this facility's population.

SUPERVISOR TIPS

- **Ask staff to name the specific categories, not just confirm general awareness that differences exist.** — Specificity reveals whether this understanding is genuinely operational.
- **Ask about a less common status category present in this population.** — This is where recognition gaps are most likely to concentrate.

EVIDENCE BASE

[37] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

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