

Hospital Standards — Full Guidance

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

17 standards · 143 criteria · Version 4.0

Standard 10 — Rehabilitation

6 criteria · 2 non-negotiable · 3 core · 1 standard-level · Version 1.0

CRITERIA IN THIS STANDARD

- 10.1 — Individualized Rehabilitation Plan Based on Functional Assessment
- 10.2 — Multidisciplinary Team Coordination
- 10.3 — Patient and Family Goal-Setting and Education
- 10.4 — Progress Measured with Validated Functional Outcome Tools
- 10.5 — Equipment and Assistive Device Provision Matches Need
- 10.6 — Discharge and Community Reintegration Planning

10.1 Individualized Rehabilitation Plan Based on Functional Assessment

NON-NEGOTIABLE

Every patient receiving rehabilitation services has an individualized plan built from a documented functional assessment, not a generic protocol applied regardless of the patient’s specific impairment and baseline function.

In plain terms: Each patient’s rehabilitation plan is genuinely built around their own actual function and impairment — not a standard template applied by

diagnosis alone.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Two patients sharing the same diagnosis can have meaningfully different functional starting points — age, comorbidities, prior fitness, and the specifics of the injury or condition all shape what a realistic and appropriate plan looks like. A generic protocol applied by diagnosis alone treats this variation as if it didn't exist, which can mean either underchallenging a patient capable of more or overreaching for one who genuinely needs a slower, more supported course.

WHAT GOOD LOOKS LIKE

- A documented functional assessment is actually performed before the plan is built.
- The plan is genuinely individualized, verifiable across several patient records.
- The plan is reassessed and adjusted as the patient's function changes.

COMMON FAILURE MODES

- A standard protocol is applied by diagnosis without a genuine individual assessment.
- Multiple patient plans read nearly identically, suggesting a template rather than individualization.
- The plan set at admission is never revisited as the patient's function evolves.

WORKED EXAMPLE

IN PRACTICE

Two patients admitted with the same hip fracture diagnosis.

BEFORE

Both patients were started on an identical standard post-hip-fracture rehabilitation protocol, despite one being a previously active 68-year-old and the other an 84-year-old with significant baseline frailty and a prior stroke affecting one side.

ACTION	The organization required a documented functional assessment — baseline mobility, cognitive status, prior function, comorbidities — completed for every rehabilitation patient within 48 hours of admission, with the plan explicitly built from that assessment rather than diagnosis alone.
AFTER	The Monitor compared the two patients' plans and found genuinely different pacing, goals, and discipline involvement reflecting their distinct functional assessments. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a standard functional assessment tool completed for every rehabilitation patient.
2. Require the plan to explicitly reference the assessment findings, not just the diagnosis.
3. Compare several current patient plans to check for genuine individualization.

The most common mistake: Applying a standard rehabilitation protocol based on diagnosis alone, without a genuine functional assessment capturing the real differences in baseline function, comorbidities, and prior fitness between patients who share the same diagnosis.

SELF-ASSESSMENT QUESTIONS

1. Is a documented functional assessment actually performed before the rehabilitation plan is built, not a generic protocol applied by diagnosis alone? — *Two patients with the same diagnosis can have very different functional starting points.*

Evidence: Functional assessment record

2. Is the plan genuinely individualized to that assessment, not a standard template with the patient's name filled in? — *Verified by comparing several patient plans for genuine difference, not just name changes.*

Evidence: Comparative plan review

3. Is the plan reassessed and adjusted as the patient’s function changes during the course of treatment? — *A plan fixed at admission may no longer reflect the patient’s progress weeks later.*
Evidence: Plan revision history

COMMON REASONS FOR A PARTIAL ANSWER

- An assessment exists but plans still read as largely standardized by diagnosis.
- Plans are set at admission and rarely revisited as function changes.

IMPLEMENTATION PLAN

When	What
Week 1	Build or formalize a standard functional assessment tool.
Week 2	Require the tool’s completion within a defined window of admission.
Week 3	Review several current plans for genuine individualization.
Ongoing	Build in a defined reassessment interval.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Comparative plan review	Compares plans across several patients with similar diagnoses for genuine individualization.

EVIDENCE BASE

World Health Organization. Rehabilitation in Health Systems. Geneva: WHO; 2017.

World Health Organization. Rehabilitation 2030: A Call for Action. Geneva: WHO; 2023.

10.2 Multidisciplinary Team Coordination

NON-NEGOTIABLE

Rehabilitation care is coordinated across the relevant disciplines — physical therapy, occupational therapy,

speech-language therapy, rehabilitation medicine, nursing, as applicable to the patient — through a genuine shared process, not separate disciplines working in isolation from each other.

In plain terms: The different rehabilitation disciplines genuinely talk to each other and coordinate the patient's care — not each working their own piece in isolation with no shared view of the whole picture.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Rehabilitation disciplines working in isolation, each documenting independently with no shared coordination point, risks working at cross-purposes or missing how progress in one area affects goals in another — a physical therapy milestone can directly change what's realistic for occupational therapy goals, for example. A coordination process that exists only at admission and discharge misses the substantial middle period where a patient's course, and therefore the right coordinated response, can shift considerably.

WHAT GOOD LOOKS LIKE

- A genuine shared coordination process exists, not just independent discipline notes.
- Coordination happens on a defined, recurring schedule, not only at the bookends.
- Staff can describe a specific instance where coordination changed the plan.

COMMON FAILURE MODES

- Each discipline documents separately with no genuine shared coordination point.
- Coordination happens only at admission and discharge, missing the interim course.
- A scheduled meeting exists but doesn't actually change care decisions.

WORKED EXAMPLE

IN PRACTICE

A stroke patient receiving physical, occupational, and speech-language therapy.

BEFORE	Each discipline documented progress independently in separate notes, with no shared meeting point. Physical therapy made faster-than-expected progress on mobility, but occupational therapy's goals weren't adjusted to reflect this for several weeks, since nobody was specifically coordinating across the notes.
ACTION	The organization instituted a weekly multidisciplinary case conference for every active rehabilitation patient, with a shared plan document updated collaboratively rather than three separate discipline-specific records.
AFTER	The Monitor reviewed a recent case conference record showing occupational therapy goals explicitly adjusted in direct response to a physical therapy milestone discussed in the same meeting. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether disciplines currently document independently with no shared coordination point.
2. Build a recurring multidisciplinary case conference, not just admission/discharge touchpoints.
3. Build a shared plan document rather than three separate discipline records.

The most common mistake: Each discipline documents progress independently with no genuine shared coordination point, meaning a significant change in one area — faster-than-expected progress, a new complication — doesn't reliably reach the other disciplines in time to adjust their own plans.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine shared coordination process — a joint case conference, a shared plan document — not just separate disciplines each documenting independently? — *Isolated discipline-specific notes with no shared coordination point is a common, specific failure.*

Evidence: Case conference record

2. Does coordination happen on a defined, recurring schedule, not only at admission and discharge? — *A patient's course can change significantly between admission and discharge without interim coordination.*

Evidence: Coordination schedule

3. Can staff from different disciplines describe a specific instance where coordination changed the care plan? — *Evidence the coordination process genuinely functions, not just exists as a scheduled meeting.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A coordination meeting exists but functions as separate updates, not genuine collaboration.**
- **Coordination happens inconsistently rather than on a fixed schedule.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current coordination practice across disciplines.
Week 2	Build a recurring multidisciplinary case conference schedule.
Week 3	Build a shared plan document replacing separate discipline-only records.
Ongoing	Spot-check whether coordination genuinely changes care decisions.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Case conference review	Checks case conference records for genuine cross-discipline plan adjustment, not parallel updates.

EVIDENCE BASE

World Health Organization. Rehabilitation in Health Systems. Geneva: WHO; 2017.

10.3

Patient and Family Goal-Setting and Education

CORE

Rehabilitation goals are set collaboratively with the patient and, where appropriate, family, in understandable terms, with the patient and family genuinely informed of realistic expectations — not goals set unilaterally by the clinical team.

In plain terms: The patient and family genuinely take part in setting rehabilitation goals, in plain language they actually understand — not goals decided by staff alone and simply announced.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Goals set unilaterally by the clinical team, however clinically sound, don't necessarily reflect what matters most to the patient — returning to a specific activity, managing independently at home, a particular functional milestone — which affects both genuine motivation and the real-world relevance of the plan. An overly optimistic picture of likely outcomes, offered to avoid a difficult conversation, sets the patient and family up for disappointment and can undermine trust once reality diverges from what they were led to expect.

WHAT GOOD LOOKS LIKE

- Goals are documented as genuinely collaborative, with visible patient input.
- Realistic expectations are honestly communicated,

COMMON FAILURE MODES

- Goals are set by the clinical team with no documented patient input.
- Expectations are kept unrealistically optimistic to

not an overly optimistic picture.

- The patient can describe their own rehabilitation goals in their own words.

avoid a difficult conversation.

- The patient can't articulate their own goals when asked directly.

WORKED EXAMPLE

IN PRACTICE

A patient recovering from a significant orthopedic injury.

BEFORE	Goals were set by the clinical team based on standard functional milestones, with the patient informed of the plan rather than consulted in setting it. The patient, a keen gardener, wasn't asked what specifically mattered to her, and the plan didn't reflect her actual priority of returning to kneeling and bending for gardening.
ACTION	The organization built a structured goal-setting conversation into the initial assessment, specifically asking the patient what activities mattered most to her, and incorporated gardening-specific functional milestones into her plan alongside the standard clinical goals.
AFTER	The Monitor asked the patient about her rehabilitation goals and she described both the clinical milestones and her gardening-specific goal clearly and confidently. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a structured goal-setting conversation into the initial assessment.
2. Specifically ask what matters most to the patient, not just clinical milestones.
3. Ask a current patient to describe their own goals, as a quick check.

The most common mistake: Setting goals based on standard clinical milestones without specifically asking the patient what

matters most to them personally, missing the real-world priority that would make the plan genuinely motivating and relevant.

SELF-ASSESSMENT QUESTIONS

1. Are goals documented as genuinely collaborative, with the patient's own input visible, not set unilaterally by staff? — *A goal-setting record showing only clinical input, with no patient voice, suggests a one-way process.*

Evidence: Goal-setting record

2. Are realistic expectations genuinely communicated, not an overly optimistic picture that sets the patient up for disappointment? — *Honest, calibrated communication, not false reassurance.*

Evidence: Communication documentation

3. Is the patient able to describe their own rehabilitation goals in their own words when asked? — *If the patient can't articulate the goals, the collaborative process likely wasn't genuine.*

Evidence: Patient interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Patient input is sought but not visibly reflected in the final documented goals.**
- **Expectations lean optimistic to avoid a difficult conversation.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a structured goal-setting conversation template.
Week 2	Train staff on honest expectation-setting technique.
Week 3	Pilot with current patients and check their ability to describe goals.
Ongoing	Spot-check patient understanding of their own goals periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Patient interview	Asks the patient directly to describe their own rehabilitation goals, checking for genuine understanding.

EVIDENCE BASE

World Health Organization. Rehabilitation 2030: A Call for Action. Geneva: WHO; 2023.

10.4

Progress Measured with Validated Functional Outcome Tools

CORE

Rehabilitation progress is tracked using a validated functional outcome measurement tool appropriate to the patient’s condition, applied consistently at defined intervals, not relying on informal clinical impression alone.

In plain terms: Progress is tracked with a real, recognized measurement tool at consistent intervals — not just an informal clinical impression of how the patient “seems to be doing.”

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Informal clinical impression, however experienced the clinician, lacks the consistency and comparability a validated tool provides — it’s considerably harder to detect a genuine plateau or subtle decline through impression alone than through a standardized measure tracked over time. Measurement that’s recorded but never actually used to inform changes to the treatment plan is documentation for its own sake, providing none of the real clinical value a functioning outcome-tracking system should offer.

WHAT GOOD LOOKS LIKE

- A validated, recognized outcome tool is actually used, not an informal note.
- The tool is applied at defined, consistent intervals.

COMMON FAILURE MODES

- Progress notes are informal, without a validated, standardized tool.
- Measurement happens sporadically, whenever convenient, not on a fixed schedule.

- Outcome measurements genuinely inform changes to the treatment plan.

- Scores are recorded but don't visibly influence subsequent treatment decisions.

WORKED EXAMPLE

IN PRACTICE

A patient whose progress appeared to plateau.

BEFORE	Progress was tracked through informal narrative notes — “making steady progress,” “doing well” — with no standardized tool. A genuine functional plateau went unnoticed for several weeks since the informal notes continued to read positively despite little measurable change.
ACTION	The organization adopted a validated functional outcome tool appropriate to its patient population, applied at a fixed weekly interval, with scores reviewed specifically for plateau or decline as part of the multidisciplinary case conference.
AFTER	The Monitor reviewed outcome scores for a recent patient and found a documented plateau identified through the tool, which triggered a plan adjustment at the next case conference. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Select a validated outcome tool appropriate to your patient population.
2. Set a fixed, consistent measurement interval.
3. Build a step connecting outcome scores directly into treatment plan review.

The most common mistake: Relying on informal narrative progress notes rather than a validated, standardized tool, which makes a genuine plateau or subtle decline considerably harder to detect compared to a consistent measurement tracked over time.

SELF-ASSESSMENT QUESTIONS

1. Is a validated, recognized outcome tool actually used, not an informal, ad hoc progress note? — *A validated tool provides a consistent, comparable measure; informal notes don't.*

Evidence: Outcome tool documentation

2. Is the tool applied at defined, consistent intervals, not sporadically whenever convenient? — *Irregular measurement makes genuine progress tracking difficult.*

Evidence: Measurement schedule

3. Do outcome measurements actually inform changes to the treatment plan, or are they recorded without influencing care? — *Measurement that doesn't feed back into the plan is documentation for its own sake.*

Evidence: Plan adjustment linked to outcome score

COMMON REASONS FOR A PARTIAL ANSWER

- **A tool is used but intervals are inconsistent.**
- **Scores are recorded but rarely visibly connected to plan changes.**

IMPLEMENTATION PLAN

When	What
Week 1	Select a validated outcome tool appropriate to the patient population.
Week 2	Set and communicate a fixed measurement interval.
Week 3	Build outcome review into the case conference agenda.
Ongoing	Spot-check whether scores visibly inform plan changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Outcome-to-plan traceability review	Traces a specific outcome measurement to a resulting treatment plan adjustment.

EVIDENCE BASE

World Health Organization. Rehabilitation 2030: A Call for Action. Geneva: WHO; 2023.

10.5

Equipment and Assistive Device Provision
Matches Need

CORE

Assistive devices and equipment — mobility aids, orthotics, adaptive equipment — are assessed, fitted, and provided to match the patient’s actual functional need, with patient and caregiver trained in correct use before discharge.

In plain terms: Equipment is genuinely matched to what the patient needs, properly fitted, and the patient and caregiver are actually shown how to use it correctly before discharge — not just handed over.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Equipment provision driven by what’s readily in stock, rather than a genuine individual assessment, can leave a patient with a device that doesn’t actually fit their specific need — a cane when a walker is genuinely required, for instance. Equipment handed over without real training in its correct use carries its own safety risk and often simply goes unused, which means the investment in providing it accomplishes nothing for the patient’s actual function.

WHAT GOOD LOOKS LIKE

- Equipment provision is based on a documented individual assessment.
- Patient and caregiver are actually trained in correct use before discharge.
- A documented follow-up process exists if the fit

COMMON FAILURE MODES

- Equipment is provided from available stock rather than a genuine fit assessment.
- Equipment is handed over with minimal or no real use training.

later proves inadequate.

- No follow-up process exists if the equipment proves a poor fit over time.

WORKED EXAMPLE

IN PRACTICE

A patient discharged with a mobility aid after a lower-limb injury.

BEFORE

A standard cane was provided from available stock at discharge, with a brief verbal mention of how to use it, but no hands-on training and no individual assessment of whether a cane was genuinely the right level of support for this specific patient's balance and strength.

ACTION

The organization built a required equipment assessment by a qualified therapist before any device is ordered, with hands-on training sessions for patient and caregiver documented before discharge, and a scheduled follow-up check within two weeks of discharge.

AFTER

The Monitor reviewed a recent discharge record showing a documented assessment, a hands-on training session with both patient and caregiver present, and a scheduled follow-up appointment. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Require a documented individual equipment assessment before any device is ordered.
2. Build a hands-on training session into the discharge process, not a verbal mention.
3. Build a scheduled follow-up check after discharge.

The most common mistake: Providing equipment from available stock with only a brief verbal explanation of its use, rather than a genuine individual fit assessment and hands-on training that

confirms the patient and caregiver can actually use it safely and correctly.

SELF-ASSESSMENT QUESTIONS

1. Is equipment provision based on a documented individual assessment, not a default or convenience-driven choice? — *Whatever's readily in stock, rather than what genuinely fits the patient's need, is a specific, checkable gap.*
Evidence: Equipment assessment record

2. Are patient and caregiver actually trained in correct use before discharge, not just handed the equipment? — *Equipment without genuine training in its use risks being unsafe or unused.*
Evidence: Training documentation

3. Is there a documented process for follow-up if the equipment later proves a poor fit? — *A fitting assessed once at discharge may not remain appropriate as the patient's needs evolve.*
Evidence: Follow-up schedule

COMMON REASONS FOR A PARTIAL ANSWER

- An assessment happens but training before discharge is brief or inconsistent.
- No follow-up check exists after the patient goes home with the equipment.

IMPLEMENTATION PLAN

When	What
Week 1	Require a documented individual equipment assessment process.
Week 2	Build a hands-on training session into the discharge checklist.
Week 3	Build a scheduled post-discharge follow-up check.
Ongoing	Spot-check discharge records for assessment and training completeness.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Discharge record review	Checks discharge records for documented equipment assessment, training, and follow-up scheduling.

EVIDENCE BASE

World Health Organization. Assistive Technology. Geneva: WHO; 2024.

10.6

Discharge and Community Reintegration Planning

STANDARD

Discharge planning for rehabilitation patients begins early in the course of treatment and genuinely addresses home environment, caregiver support, community resources, and follow-up therapy — not a last-minute checklist completed at the point of discharge.

In plain terms: Discharge planning genuinely starts early and actually addresses the patient’s real home situation and ongoing support — not a rushed checklist filled out the day they leave.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Discharge planning that begins only in the final days before discharge leaves little real time to address gaps that take genuine lead time to resolve — arranging a home modification, connecting with a community resource, or securing follow-up therapy capacity. Generic discharge instructions that don’t specifically address the patient’s actual home environment and caregiver situation miss exactly the kind of practical, individual risk — a home with stairs and no support for a patient with limited mobility, for instance — that good planning exists to catch.

WHAT GOOD LOOKS LIKE

- Discharge planning genuinely begins early in the treatment course.
- The plan specifically addresses the patient's actual home environment and caregiver support.
- Follow-up therapy or community resource connection is actually arranged, not just suggested.

COMMON FAILURE MODES

- Discharge planning happens only in the final days, leaving no time to resolve real gaps.
- Instructions are generic rather than addressing the specific home situation.
- Follow-up therapy is recommended verbally but no actual referral or appointment is made.

WORKED EXAMPLE

IN PRACTICE

A patient with significant mobility limitations discharged to a home with stairs.

BEFORE

Discharge planning began two days before the patient left, too late to meaningfully address that her home had a flight of stairs to the only bathroom and no family member available to help during the day. She was discharged with generic written instructions and a verbal suggestion to “arrange outpatient therapy.”

ACTION

The organization required discharge planning to begin within the first week of admission for any rehabilitation patient, with a specific home environment and caregiver support assessment, and a direct outpatient therapy referral made before discharge rather than a verbal suggestion.

AFTER

The Monitor reviewed a subsequent discharge record showing early planning initiation, a documented home environment assessment with an arranged solution for the stairs issue, and a confirmed outpatient therapy appointment booked before discharge. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Require discharge planning to begin within a defined early window of admission.
2. Build a specific home environment and caregiver support assessment into the process.
3. Replace verbal follow-up therapy suggestions with actual referrals made before discharge.

The most common mistake: Beginning discharge planning only in the final days before the patient leaves, which leaves too little time to genuinely address a real home environment or caregiver gap that takes actual lead time to resolve.

SELF-ASSESSMENT QUESTIONS

1. Does discharge planning genuinely begin early in the treatment course, not only in the final days before discharge? — *Early planning allows time to actually address gaps, such as a home environment needing modification.*

Evidence: Discharge planning initiation date

2. Does the plan specifically address the patient's actual home environment and caregiver support, not generic discharge instructions? — *A home with stairs and no support, for a patient with limited mobility, is a specific, checkable risk.*

Evidence: Home environment assessment

3. Is follow-up therapy or community resource connection actually arranged, not just recommended verbally? — *A verbal recommendation with no actual referral or appointment often doesn't result in follow-through.*

Evidence: Referral or appointment confirmation

COMMON REASONS FOR A PARTIAL ANSWER

- **Planning starts a little earlier but still leaves limited time for real problem-solving.**
- **Follow-up therapy is suggested but not confirmed with an actual appointment.**

IMPLEMENTATION PLAN

When	What
Week 1	Set a required early window for discharge planning initiation.
Week 2	Build a home environment and caregiver support assessment tool.
Week 3	Replace verbal follow-up suggestions with a direct referral process.
Ongoing	Spot-check discharge records for planning initiation timing.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Discharge planning timeline review	Checks the discharge planning initiation date against admission date and confirms referral completion.

EVIDENCE BASE

World Health Organization. Rehabilitation in Health Systems. Geneva: WHO; 2017.

← Hospital Standards — all standards

Self-assess against these criteria →

← Standard 9 — Refugee & Migrant Health

Standard 11 — Critical Care
→

Standard 11 — Critical Care

6 criteria · 3 non-negotiable · 2 core · 1 standard-level · Version 1.0

CRITERIA IN THIS STANDARD

- 11.1 — Continuous Physiological Monitoring Appropriate to Acuity
- 11.2 — Nurse-to-Patient Ratio Matches Acuity
- 11.3 — Rapid Response and Deterioration Recognition System
- 11.4 — Sedation and Delirium Management Protocol
- 11.5 — Family Communication and Presence Policy
- 11.6 — End-of-Life and Withdrawal of Care Protocol

11.1 Continuous Physiological Monitoring Appropriate to Acuity

NON-NEGOTIABLE

Every critical care patient is continuously monitored with equipment and alarm parameters individually set to their clinical condition, with alarms genuinely responded to, not silenced or ignored due to alarm fatigue.

In plain terms: Every critical care patient is genuinely watched continuously, with alarm settings actually tailored to them — and alarms get a real response, not

silenced because staff have grown used to tuning them out.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Alarm fatigue — where the sheer volume of alarms, many clinically insignificant, leads staff to delay response or mentally tune them out — is a well-documented and specific patient safety risk in critical care settings. Generic factory-default alarm parameters, left unadjusted to the individual patient's actual clinical baseline, can be essentially meaningless for that specific patient, triggering either excessive false alarms or missing genuinely significant changes.

WHAT GOOD LOOKS LIKE

- Alarm parameters are individually set for each patient's actual condition.
- A documented, genuine response time standard exists, verified against practice.
- Equipment is checked and calibrated on a fixed schedule with a failure process.

COMMON FAILURE MODES

- Alarm parameters are left on generic factory defaults.
- Alarms are frequently silenced or ignored due to alarm fatigue.
- No documented process exists for monitoring equipment failure.

WORKED EXAMPLE

IN PRACTICE

A critical care unit reviewing its alarm response practice.

BEFORE

Alarm parameters remained on generic factory defaults for most patients, generating frequent false or clinically insignificant alarms, which over time led staff to develop a pattern of delayed response, silencing alarms before fully assessing them.

ACTION	The unit built a required alarm individualization step at the start of each shift, setting parameters to the specific patient's clinical baseline, which measurably reduced false alarm volume and, with it, alarm fatigue.
AFTER	The Monitor observed alarm parameters set individually for several current patients and reviewed response time logs showing genuine, prompt response. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether alarm parameters are currently individualized or left on defaults.
2. Build a required individualization step at shift start.
3. Build a documented response time standard and track actual response.

The most common mistake: Leaving alarm parameters on generic factory defaults, which generates frequent clinically insignificant alarms and over time trains staff into the dangerous pattern of alarm fatigue, delaying or skipping genuine response.

SELF-ASSESSMENT QUESTIONS

1. Are alarm parameters individually set for each patient's actual condition, not left on generic factory defaults? — *Generic defaults can be clinically meaningless for a specific patient's baseline.*

Evidence: Alarm parameter record

2. Is there a documented, genuine response time standard for alarms, verified against actual practice? — *Alarm fatigue, where frequent alarms lead to delayed or absent response, is a well-documented critical care risk.*

Evidence: Response time log

3. Is monitoring equipment checked and calibrated on a fixed schedule, with a documented process for equipment failure? — *Equipment failure in critical care carries immediate, serious risk.*

Evidence: Calibration and failure-process documentation

COMMON REASONS FOR A PARTIAL ANSWER

- Parameters are individualized at admission but not revisited as condition changes.
- A response time standard exists but isn’t actually monitored.

IMPLEMENTATION PLAN

When	What
Week 1	Audit current alarm parameter practice across the unit.
Week 2	Build a required individualization step at shift start.
Week 3	Build a response time standard and tracking method.
Ongoing	Review alarm response logs periodically for fatigue patterns.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Unit observation	Observes alarm parameter individualization and actual staff response to alarms during a unit visit.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer. Geneva: WHO; 2021.

11.2 Nurse-to-Patient Ratio Matches Acuity

NON-NEGOTIABLE

A defined nurse-to-patient ratio appropriate to critical care acuity is maintained at all times, including nights and weekends, with a documented escalation process when staffing falls below the required ratio — not an aspirational standard that quietly erodes under pressure.

In plain terms: The defined nurse-to-patient ratio genuinely holds at all hours, including nights and weekends — with a real, used escalation path when it

can't be met, not a ratio that exists on paper but erodes under pressure.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Off-hours staffing — nights, weekends — is specifically where nurse-to-patient ratios most commonly erode under pressure, precisely because oversight tends to be lighter during these periods than during well-staffed daytime weekday shifts. A ratio with no genuine escalation process for when staffing falls below the standard functions, in practice, as merely an aspiration rather than a real operational requirement — the escalation process is what distinguishes the two.

WHAT GOOD LOOKS LIKE

- The ratio is maintained and verified across all shifts, not only daytime weekdays.
- A documented escalation process exists for below-ratio staffing.
- A documented instance exists of this escalation process actually being used.

COMMON FAILURE MODES

- The ratio holds on weekdays but quietly erodes on nights and weekends.
- No real escalation process exists for below-ratio situations.
- No example exists of the escalation process ever actually being used.

WORKED EXAMPLE

IN PRACTICE

A critical care unit's weekend night shift staffing pattern.

BEFORE

The defined ratio was consistently met on weekday daytime shifts, but weekend nights occasionally ran below ratio due to staffing shortages, with nurses simply managing the increased load without any formal escalation or documented review.

ACTION	The unit built a required escalation process — notifying the nursing supervisor and documenting the below-ratio period as a quality event — applied identically regardless of time of day or day of week.
AFTER	The Monitor reviewed quality event logs and found weekend night below-ratio periods now consistently documented and escalated, matching weekday practice. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check actual staffing records across all shifts, not just daytime weekdays.
2. Build a required escalation and documentation process for below-ratio staffing.
3. Apply the process identically regardless of time of day.

The most common mistake: A nurse-to-patient ratio that holds reliably on well-staffed weekday daytime shifts but quietly erodes on nights and weekends, with no formal escalation or documentation when this happens.

SELF-ASSESSMENT QUESTIONS

1. Is the defined ratio actually maintained, verified against real staffing records across different shifts, not just daytime weekday staffing? — *Off-hours staffing pressure is a common, specific point where ratios erode.*

Evidence: Staffing record across shift types

2. Is there a documented escalation process when staffing falls below the required ratio? — *Not an informal expectation that staff will manage, but a real, actionable escalation path.*

Evidence: Escalation procedure

3. Is there a documented instance of this escalation process actually being used? — *Evidence the process functions in practice, not just exists on paper.*

Evidence: Escalation event record

COMMON REASONS FOR A PARTIAL ANSWER

- The ratio holds on weekdays but staffing records for nights/weekends aren’t closely tracked.
- An escalation process exists but has never actually been used or tested.

IMPLEMENTATION PLAN

When	What
Week 1	Audit staffing records across all shift types for the past quarter.
Week 2	Build a formal escalation and documentation process.
Week 3	Brief all shifts, with particular attention to off-hours staff.
Ongoing	Track escalation events specifically for off-hours patterns.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Staffing record review	Reviews staffing records specifically for off-hours and weekend consistency against the defined ratio.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer. Geneva: WHO; 2021.

11.3 Rapid Response and Deterioration Recognition System

NON-NEGOTIABLE

A structured early-warning scoring system is used to detect patient deterioration, with a defined rapid response mechanism that staff can activate directly, without needing to escalate through multiple layers before genuine help arrives.

In plain terms: A real, structured tool catches early deterioration, and any staff member can trigger rapid response directly — not after working through several layers of approval first.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A structured, scored early-warning system catches subtle but genuine deterioration considerably more reliably than relying on informal clinical impression, particularly for trends that develop gradually rather than presenting as a sudden, obvious event. A rapid response mechanism that requires working through multiple layers of approval before activation directly undermines its own purpose — the entire value of “rapid” depends on the person who notices deterioration being able to act immediately, not after a delay for permission.

WHAT GOOD LOOKS LIKE

- A structured, scored early-warning system is actually used, not informal impression.
- Any staff member can activate rapid response directly, without multi-layer approval.
- A documented, verified response time exists from activation to team arrival.

COMMON FAILURE MODES

- Deterioration detection relies on informal clinical impression alone.
- Activation requires working through a chain of approval before help arrives.
- Response time is assumed rather than genuinely measured.

WORKED EXAMPLE

IN PRACTICE

A junior nurse noticing subtle signs of deterioration in a patient.

BEFORE

The junior nurse noticed subtle but concerning changes, but the facility’s unwritten culture expected staff to first consult the charge nurse, who would then decide whether to escalate

	further, adding a meaningful delay before any rapid response was actually activated.
ACTION	The hospital adopted a validated early-warning scoring tool with explicit, publicized authority for any staff member to activate rapid response directly upon reaching a threshold score, with no requirement for prior approval.
AFTER	The Monitor reviewed a subsequent case where a junior staff member activated rapid response directly, with the team arriving within the documented, verified target time. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Adopt a validated, scored early-warning tool if not already in use.
2. Explicitly grant and publicize direct activation authority to all staff.
3. Measure and document actual rapid response team arrival time.

The most common mistake: An unwritten culture where staff feel they need to first consult a more senior colleague before activating rapid response, adding a delay that works directly against the purpose of having a rapid response system.

SELF-ASSESSMENT QUESTIONS

1. Is a structured, scored early-warning system actually used, not informal clinical impression alone? — *A structured tool catches early deterioration more reliably than impression alone.*

Evidence: Early-warning scoring documentation

2. Can any staff member activate the rapid response directly, without needing multiple layers of approval first? — *A response requiring lengthy escalation before activation undermines the purpose of a rapid response system.*

Evidence: Activation policy

3. Is there a documented, verified response time from activation to the responding team's arrival? — *An assumed response time, never actually measured, often proves more optimistic than reality.*
Evidence: Response time log

COMMON REASONS FOR A PARTIAL ANSWER

- A policy grants direct activation but an informal culture still expects prior consultation.
- Response time is assumed rather than genuinely measured and tracked.

IMPLEMENTATION PLAN

When	What
Week 1	Adopt or confirm a validated early-warning scoring tool.
Week 2	Explicitly grant and publicize direct activation authority.
Week 3	Build a response time measurement and tracking system.
Ongoing	Review activation events for any sign of hesitation or delay.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Junior staff interview	Asks a junior staff member directly whether they can activate rapid response without prior approval.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer. Geneva: WHO; 2021.

11.4 Sedation and Delirium Management Protocol

CORE

A written protocol governs sedation level targets and delirium screening for critical care patients, with sedation minimized to the clinically necessary level and delirium

actively screened for on a defined schedule, not assumed absent without active checking.

In plain terms: Sedation is kept to a specific, deliberately targeted level, and delirium is genuinely, actively screened for on a schedule — not assumed absent just because nobody happened to notice anything obvious.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Sedation deeper than clinically necessary carries its own well-documented risks, which is why a defined, deliberately targeted sedation goal — rather than a default “keep comfortable” approach without a specific target — matters as a genuine clinical practice, not just a documentation exercise. Delirium, particularly its hypoactive form, is frequently subtle and easily missed without active, scheduled screening using a validated tool; assuming its absence because nothing seemed obviously wrong is a specific, well-documented detection gap.

WHAT GOOD LOOKS LIKE

- Sedation is targeted to a defined, documented goal, not a vague default.
- Delirium is actively screened for with a validated tool on a defined schedule.
- A positive delirium screen triggers a documented clinical response.

COMMON FAILURE MODES

- Sedation follows a general “comfortable” approach with no specific target.
- Delirium screening happens only informally, if a patient seems obviously affected.
- A positive screen is noted but doesn’t trigger a genuine clinical response.

WORKED EXAMPLE

IN PRACTICE

A critical care unit reviewing its delirium detection practice.

BEFORE	Delirium was noted informally only when a patient displayed obvious agitation, missing the more common hypoactive form, which presents as quiet withdrawal rather than visible distress and is correspondingly easy to overlook without active screening.
ACTION	The unit adopted a validated delirium screening tool applied on every shift, specifically trained to catch the hypoactive presentation, with a positive screen triggering a documented review of contributing factors and a management plan.
AFTER	The Monitor reviewed screening records and found consistent per-shift screening, with a recent positive screen showing a documented, actioned response. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Adopt a validated delirium screening tool covering both hyperactive and hypoactive presentations.
2. Build a defined sedation target documented for each patient.
3. Build a required response process for a positive delirium screen.

The most common mistake: Relying on informal observation to detect delirium, which reliably catches the more visible hyperactive presentation but frequently misses the quieter, equally significant hypoactive form without active, scheduled screening.

SELF-ASSESSMENT QUESTIONS

1. Is sedation level actually targeted to a defined, documented goal, not a default “keep comfortable” approach without a specific target? — *Deeper sedation than clinically necessary carries its own documented risks.*

Evidence: Sedation target documentation

2. Is delirium actively screened for using a validated tool on a defined schedule, not just noticed informally if obvious? — *Delirium can be subtle, particularly the hypoactive form, and is frequently missed*

without active screening.

Evidence: Screening record

3. Does a positive delirium screen trigger a documented clinical response, not just a note in the chart? — *Detection without a genuine response provides limited protective value.*

Evidence: Response-to-screen traceability

COMMON REASONS FOR A PARTIAL ANSWER

- A screening tool is used but not consistently on every shift.
- Positive screens are documented but the follow-up response is inconsistent.

IMPLEMENTATION PLAN

When	What
Week 1	Adopt a validated delirium screening tool.
Week 2	Build a defined sedation target requirement per patient.
Week 3	Build a required response process for positive screens.
Ongoing	Review screening consistency and response traceability.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Screening-to-response traceability review	Traces a specific positive delirium screen to a resulting documented clinical response.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer. Geneva: WHO; 2021.

11.5 Family Communication and Presence Policy

CORE

A structured process ensures family receives regular, understandable updates on the patient's condition, with a clear, genuinely applied family presence policy — not family

access or communication left to vary by which staff member happens to be on shift.

In plain terms: Families get genuinely regular updates they can actually understand, and the visiting policy is applied the same way no matter which staff member is on shift — not a lottery depending on who’s working.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Inconsistent family communication, dependent on which clinician happens to be available at a given moment, is a well-documented source of significant family distress in critical care settings, independent of the clinical outcome itself. A family presence policy that varies meaningfully by which staff member is on shift functions, in practice, as no real policy at all — families experience this inconsistency directly and it erodes trust in the unit’s overall care.

WHAT GOOD LOOKS LIKE

- Families receive genuinely regular updates in understandable terms.
- The presence policy is applied consistently, not varying by staff member.
- A structured family conference process exists at defined clinical points.

COMMON FAILURE MODES

- Updates are sporadic, dependent on which clinician happens to be available.
- Presence policy application varies meaningfully depending on who’s on shift.
- Family conferences happen only if family specifically requests one.

WORKED EXAMPLE

IN PRACTICE

A family navigating a loved one’s extended critical care stay.

BEFORE

Updates to family depended heavily on which physician was on shift — some provided detailed

	daily updates, others only spoke with family if specifically asked. The visiting policy was also applied inconsistently, with some nurses more flexible than others about outside standard hours.
ACTION	The unit built a required daily family update, delivered by whoever is the treating clinician that day, using a structured format ensuring consistent content regardless of individual communication style, alongside a clearly written and consistently applied presence policy.
AFTER	The Monitor interviewed a current patient's family, who confirmed receiving consistent daily updates and experiencing the presence policy applied the same way regardless of which staff member was present. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a required daily family update with a structured content format.
2. Write a clear, specific presence policy and brief all staff on it.
3. Build a structured family conference trigger at defined clinical points.

The most common mistake: Family communication frequency and content varying significantly depending on which individual clinician happens to be treating the patient that day, rather than a structured, consistent update process regardless of who's on shift.

SELF-ASSESSMENT QUESTIONS

1. Do families receive genuinely regular updates in understandable terms, not sporadic updates that depend on which clinician happens to be available? — *Inconsistent communication is a well-documented source of family distress in critical care.*

Evidence: Family communication log

2. Is the family presence policy applied consistently, not varying significantly by which staff member is on shift? — *A policy applied inconsistently functions, in practice, as no real policy at all.*

Evidence: Family interview

3. Is there a structured process for a family conference at defined clinical points, such as a significant change in prognosis? — A *proactive structured conversation, not communication that happens only if family specifically asks.*

Evidence: Family conference trigger policy

COMMON REASONS FOR A PARTIAL ANSWER

- Updates happen but content and consistency vary by clinician.
- The presence policy exists but staff apply it with meaningful individual variation.

IMPLEMENTATION PLAN

When	What
Week 1	Build a structured daily family update format.
Week 2	Write and distribute a clear, specific presence policy.
Week 3	Build a structured family conference trigger process.
Ongoing	Interview families periodically for consistency feedback.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Family interview	Asks a current patient's family directly about communication consistency and presence policy experience.

EVIDENCE BASE

World Health Organization. People-Centred and Integrated Health Services: An Overview of the Evidence. Geneva: WHO; 2015.

11.6 End-of-Life and Withdrawal of Care Protocol

STANDARD

A written protocol governs end-of-life decision-making and withdrawal of life-sustaining treatment in critical care, including family involvement, ethics consultation access,

and palliative support — not decisions made inconsistently depending on the individual clinician’s own approach.

In plain terms: End-of-life decisions follow a real, consistent protocol — with genuine ethics support and palliative care woven in alongside active treatment, not left to vary by whichever clinician happens to be in charge.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Significant, unexplained variation in end-of-life decision-making approach between individual clinicians, absent a genuine shared protocol, raises real concerns about consistency and fairness in some of the most consequential decisions a critical care unit makes.

Palliative support treated as a separate referral that only happens after active treatment has fully stopped, rather than genuinely integrated alongside ongoing treatment decisions, misses the real value palliative expertise can add earlier in a patient’s course.

WHAT GOOD LOOKS LIKE

- A written protocol genuinely guides end-of-life decision-making consistently.
- Ethics consultation is genuinely accessible and actually used when needed.
- Palliative support is integrated alongside active treatment, not only after.

COMMON FAILURE MODES

- Approach varies significantly by individual clinician, absent a shared protocol.
- Ethics consultation exists on paper but is rarely actually used.
- Palliative support is treated as a separate step only after treatment stops.

WORKED EXAMPLE

IN PRACTICE

A unit reviewing variation in end-of-life decision-making approach.

BEFORE	End-of-life decisions were handled according to each individual physician's own practice style, with noticeably different approaches to family involvement and timing of withdrawal discussions, and ethics consultation rarely used despite being technically available.
ACTION	The unit built a written protocol standardizing family involvement steps and the timing of palliative consultation, with explicit encouragement and a simple referral process for ethics consultation whenever genuine uncertainty exists.
AFTER	The Monitor reviewed several recent end-of-life cases and found consistent protocol adherence across different treating physicians, with a documented ethics consultation used in one genuinely complex case. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a written protocol standardizing family involvement and decision steps.
2. Simplify and promote the ethics consultation referral process.
3. Build a trigger point for palliative involvement alongside, not after, active treatment.

The most common mistake: End-of-life decision-making left to vary significantly by individual clinician approach, absent a genuine shared protocol, with ethics consultation technically available but rarely actually used in practice.

SELF-ASSESSMENT QUESTIONS

1. Does a written protocol genuinely guide end-of-life decision-making, not left to vary significantly by individual clinician approach?
— *Significant unexplained variation in approach between clinicians is a specific, checkable gap.*
Evidence: Written protocol

2. Is ethics consultation genuinely accessible when needed, not a resource that exists on paper but is rarely actually used? — *Verified against actual recent use, not only the existence of an ethics committee.*
Evidence: Ethics consultation usage record

3. Is palliative support genuinely integrated, not treated as a separate referral that happens only after active treatment has fully stopped? — *Palliative support alongside, not only after, active treatment decisions.*
Evidence: Palliative involvement timing

COMMON REASONS FOR A PARTIAL ANSWER

- **A protocol exists but adherence varies in practice.**
- **Ethics consultation is available but staff rarely actually use it.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current variation in end-of-life decision-making approach.
Week 2	Build a written, standardized protocol.
Week 3	Simplify the ethics consultation referral process.
Ongoing	Review end-of-life cases periodically for protocol adherence.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Case review	Reviews several end-of-life cases across different treating clinicians for protocol consistency.

EVIDENCE BASE

World Health Organization. Palliative Care. Geneva: WHO; 2020.

← **Hospital Standards — all standards**

Self-assess against these criteria →

← **Standard 10 —
Rehabilitation**

**Standard 12 — Organ &
Tissue Transplant** →

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Standard 12 — Organ & Tissue Transplant

6 criteria · 3 non-negotiable · 2 core · 1 standard-level · Version 1.0

CRITERIA IN THIS STANDARD

- 12.1 — Donor Consent Obtained Through a Process Independent of the Transplant Team
- 12.2 — Organ Allocation Follows a Transparent, Documented Protocol
- 12.3 — No Financial Incentive to Donor or Family
- 12.4 — Recipient Evaluation and Informed Consent Process
- 12.5 — Organ and Tissue Traceability, End to End
- 12.6 — Post-Transplant Follow-Up and Outcome Tracking

12.1 Donor Consent Obtained Through a Process Independent of the Transplant Team

NON-NEGOTIABLE

Donor or donor-family consent for organ or tissue donation is obtained through a process genuinely independent of the transplant team requesting the organ, with the independence structurally built in — not a theoretical separation undermined by the same staff being involved in both roles.

In plain terms: The person asking a family for consent to donate has no personal stake in whether they say yes — a genuine, structural separation from the team that would actually use the organ, not just a separation on paper.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

This separation exists because a transplant team member, however well-intentioned, has an inherent conflict of interest when approaching a grieving family about donation — their professional investment in a successful transplant outcome is in direct tension with the family’s need for an uninfluenced decision. A theoretical separation, where staff are nominally distinct but still report through the same leadership or regularly interact professionally, doesn’t provide the genuine independence this criterion requires.

WHAT GOOD LOOKS LIKE

- The person obtaining consent is genuinely organizationally separate from the transplant team.
- A documented process ensures no transplant-team-affiliated person approaches the family.
- Staff can describe this separation clearly and confidently.

COMMON FAILURE MODES

- Separation exists in title only, with shared leadership or close working relationships.
- No documented process exists specifically preventing transplant-team contact with the family.
- Staff struggle to clearly explain how or why the separation functions.

WORKED EXAMPLE

IN PRACTICE

A hospital reviewing its donor consent process structure.

BEFORE

Consent conversations were handled by a coordinator who, while not a transplant surgeon, reported to the same department head as the transplant team and worked closely with them on

	a daily basis, creating a working relationship that undermined genuine independence.
ACTION	The hospital restructured the consent coordination role to report through an entirely separate organizational line, with explicit policy prohibiting any transplant team member from being present during or involved in the consent conversation.
AFTER	The Monitor reviewed the organizational structure and confirmed the consent coordinator's reporting line was genuinely separate, with staff able to clearly describe the separation when asked. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Map the current reporting structure for consent coordination versus the transplant team.
2. Build a genuine organizational separation, not just a different job title.
3. Write an explicit policy prohibiting transplant team involvement in consent conversations.

The most common mistake: Creating a distinct job title for consent coordination while leaving the reporting structure and working relationships functionally connected to the transplant team, which undermines the genuine independence this criterion requires.

SELF-ASSESSMENT QUESTIONS

1. Is the person obtaining consent genuinely organizationally separate from the transplant team, not just nominally distinct while reporting to the same leadership? — *A structural, not just a titular, separation is what actually protects against conflict of interest.*
Evidence: Organizational structure documentation
2. Is there a documented process ensuring the family or donor is never approached by someone with a direct stake in the transplant outcome? — *The specific person requesting consent should have no*

personal or professional interest in a “yes” answer.
Evidence: Written policy

3. Can staff describe this separation clearly and confidently when asked? — If staff can’t articulate how the separation works, it may not be genuinely built into practice.
Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- A distinct role exists but shares leadership or close working relationships with the transplant team.
- Staff know a separation policy exists but can’t clearly explain how it functions.

IMPLEMENTATION PLAN

When	What
Week 1	Map the current consent coordination reporting structure.
Week 2	Build a genuine organizational separation from the transplant team.
Week 3	Write and distribute an explicit non-involvement policy.
Ongoing	Spot-check staff understanding of the separation.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Organizational structure review	Reviews the reporting structure to confirm genuine separation between consent coordination and the transplant team.

EVIDENCE BASE

World Health Organization. WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation. Geneva: WHO; 2010 (updated 2024).

12.2 Organ Allocation Follows a Transparent, Documented Protocol

NON-NEGOTIABLE

Organ allocation decisions follow a written, transparent protocol based on clinical criteria, applied consistently, with any deviation from the standard protocol specifically documented and justified — not informal decisions vulnerable to undue influence.

In plain terms: Who gets an organ follows a real, written, consistent protocol based on clinical criteria — and any exception is specifically documented and justified, not an informal judgment call.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Informal allocation decisions, made case by case without a consistent written protocol, are genuinely vulnerable to undue influence — whether financial, social, or personal — precisely because there’s no documented standard to hold the decision against. An allocation protocol that exists on paper but isn’t actually available for independent review provides limited real transparency; genuine transparency means a decision can actually be examined after the fact, not merely that a document describing the intended process exists somewhere.

WHAT GOOD LOOKS LIKE

- A written protocol genuinely governs allocation decisions, applied consistently.
- Any deviation is specifically documented with a clear clinical justification.
- The protocol and decision record are available for independent review.

COMMON FAILURE MODES

- Allocation relies on informal clinical judgment applied case by case.
- Deviations from protocol happen without documented justification.
- The protocol exists but decision records aren’t genuinely accessible for review.

WORKED EXAMPLE

IN PRACTICE

A transplant program reviewing its allocation decision records.

BEFORE	A written allocation protocol existed, but several recent decisions deviated from it without any documented justification, with the deviations only discoverable by closely comparing the protocol's stated criteria against actual outcomes.
ACTION	The program built a required justification field for any protocol deviation, reviewed by a separate oversight committee, with all allocation decisions and justifications logged in a reviewable record.
AFTER	The Monitor reviewed the allocation decision log and found a recent deviation with a clear, documented clinical justification reviewed by the oversight committee. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build or confirm a written allocation protocol based on clinical criteria.
2. Build a required justification field for any protocol deviation.
3. Build an independent review mechanism for allocation decisions.

The most common mistake: A protocol deviation occurring without a documented justification, discoverable only by closely comparing actual decisions against the protocol's stated criteria, rather than being flagged and reviewed at the time it happens.

SELF-ASSESSMENT QUESTIONS

1. Does a written protocol genuinely govern allocation decisions, not informal judgment applied case by case? — *A written, consistent protocol is a specific, checkable safeguard against undue influence.*
Evidence: Written allocation protocol
2. Is any deviation from the standard protocol specifically documented with a clear clinical justification? — *An undocumented*

deviation is a specific, checkable gap that undermines the protocol's purpose.

Evidence: Deviation justification record

3. Is the allocation protocol and decision record available for independent review? — *Genuine transparency means a decision can actually be reviewed, not just exist on paper.*

Evidence: Reviewable decision log

COMMON REASONS FOR A PARTIAL ANSWER

- **A protocol exists but deviations aren’t consistently documented.**
- **Decision records exist but aren’t genuinely accessible for independent review.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm or build a written allocation protocol.
Week 2	Build a required deviation justification field.
Week 3	Build an independent review mechanism.
Ongoing	Audit allocation decisions periodically for protocol consistency.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Allocation decision log review	Reviews recent allocation decisions for protocol adherence and documented justification for any deviation.

EVIDENCE BASE

World Health Organization. WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation. Geneva: WHO; 2010 (updated 2024).

12.3 No Financial Incentive to Donor or Family

NON-NEGOTIABLE

No financial payment or material incentive, beyond legitimate reimbursement of documented direct costs, is offered to a donor or donor family in connection with organ or tissue donation, with staff trained to recognize and refuse any such arrangement.

In plain terms: No payment or material incentive is ever offered for donation, beyond actual documented direct costs — and staff genuinely know the difference and know how to refuse an improper arrangement.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

The prohibition on financial incentive for organ and tissue donation is a foundational, internationally recognized principle specifically protecting against exploitation, particularly of vulnerable individuals or families under financial pressure who might otherwise feel coerced toward a decision they wouldn't otherwise make. The distinction between legitimate reimbursement of genuinely documented direct costs and a prohibited incentive needs to be concrete and well understood by staff, not left to individual judgment in a sensitive, emotionally charged moment.

WHAT GOOD LOOKS LIKE

- A clear, written policy explicitly prohibits incentive beyond legitimate cost reimbursement.
- Staff are trained to recognize the concrete distinction between reimbursement and incentive.
- A documented process exists for reporting any suspected violation.

COMMON FAILURE MODES

- No specific written prohibition exists beyond a general assumed understanding.
- Staff lack concrete training on what distinguishes reimbursement from incentive.
- No real reporting mechanism exists for a suspected violation.

WORKED EXAMPLE

IN PRACTICE

A hospital training new staff on donation-related policy.

BEFORE	Staff understood generally that payment for donation was prohibited, but had no specific training on what counted as legitimate documented cost reimbursement versus a prohibited incentive, leaving the distinction to individual judgment in the moment.
ACTION	The hospital built specific training with concrete examples distinguishing legitimate reimbursement — documented travel or lodging costs directly tied to the donation process — from prohibited incentive, with a clear, anonymous reporting pathway for any suspected violation.
AFTER	The Monitor interviewed staff and found they could clearly articulate the distinction with concrete examples, and confirmed the reporting pathway was known and accessible. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Write a specific, explicit policy with concrete examples of the reimbursement/incentive line.
2. Build training staff actually complete, not just a policy document distributed.
3. Build a clear, accessible reporting pathway for suspected violations.

The most common mistake: Relying on a general, assumed understanding that payment is prohibited, without specific training giving staff concrete examples of what distinguishes legitimate cost reimbursement from a prohibited financial incentive.

SELF-ASSESSMENT QUESTIONS

1. Is there a clear, written policy explicitly prohibiting financial incentive beyond legitimate documented cost reimbursement? — A

specific, written prohibition, not an assumed understanding.

Evidence: Written policy

2. Are staff trained to recognize what counts as a legitimate reimbursement versus a prohibited incentive? — *The distinction needs to be concrete and understood, not left to individual judgment in the moment.*

Evidence: Training record with concrete examples

3. Is there a documented process for reporting any suspected violation of this policy? — *A real, actionable reporting pathway, not just a policy statement with no mechanism behind it.*

Evidence: Reporting pathway documentation

COMMON REASONS FOR A PARTIAL ANSWER

- A policy exists but training lacks concrete, specific examples.
- A reporting pathway exists on paper but staff aren't confident using it.

IMPLEMENTATION PLAN

When	What
Week 1	Write a specific policy with concrete reimbursement/incentive examples.
Week 2	Build and deliver staff training on the policy.
Week 3	Build a clear, accessible reporting pathway.
Ongoing	Refresh training periodically and verify reporting pathway awareness.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks staff to describe the reimbursement/incentive distinction with concrete examples.

EVIDENCE BASE

World Health Organization. WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation. Geneva: WHO; 2010 (updated 2024).

Transplant recipients undergo a documented evaluation against clinical eligibility criteria, with genuine informed consent covering realistic outcomes, risks, and the source of the organ or tissue where legally and clinically relevant — not a general surgical consent treated as sufficient.

In plain terms: Recipients are genuinely evaluated against real clinical criteria, and their consent actually covers transplant-specific risks and outcomes — not a generic surgical consent form treated as covering everything.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A referral for transplant evaluation is a starting point, not a documented eligibility determination in itself — treating the two as equivalent overlooks the genuine clinical assessment this decision requires. A generic surgical consent form, while covering standard operative risks, doesn't address the specific considerations unique to transplant — realistic graft survival rates, rejection risk, lifelong immunosuppression — which is why genuine, transplant-specific informed consent, with understanding actually verified rather than merely a signature obtained, matters here.

WHAT GOOD LOOKS LIKE

- Recipient evaluation against clinical eligibility criteria is actually documented.
- Informed consent genuinely covers transplant-specific outcomes and risks.
- The recipient's understanding is

COMMON FAILURE MODES

- A referral is treated as equivalent to a documented eligibility determination.
- A generic surgical consent form is used without transplant-specific content.
- Consent is obtained as a signature with no genuine

genuinely verified, not just
a signature obtained.

verification of
understanding.

WORKED EXAMPLE

IN PRACTICE

A kidney transplant candidate's evaluation and consent process.

BEFORE	The candidate's referral from their nephrologist was treated as sufficient eligibility documentation, with the hospital's standard surgical consent form used, covering general operative risks but not specifically addressing graft survival rates or lifelong immunosuppression requirements.
ACTION	The hospital built a specific transplant eligibility evaluation, documented separately from the referral, and a transplant-specific consent process including a teach-back verification step to confirm genuine understanding.
AFTER	The Monitor reviewed a recent recipient's file and found a documented eligibility evaluation distinct from the referral, transplant-specific consent content, and a teach-back verification record. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a documented eligibility evaluation distinct from the referral.
2. Build transplant-specific consent content, not a generic surgical form.
3. Build a teach-back or equivalent understanding-verification step.

The most common mistake: Treating a physician's referral for transplant evaluation as equivalent to a documented eligibility determination, and using a generic surgical consent form that doesn't address the specific risks and realistic outcomes unique to transplant.

SELF-ASSESSMENT QUESTIONS

1. Is recipient evaluation against clinical eligibility criteria actually documented, not assumed from referral alone? — *A referral for transplant evaluation is not the same as a documented eligibility determination.*

Evidence: Eligibility evaluation record

2. Does informed consent genuinely cover realistic outcomes and risks specific to transplant, not a generic surgical consent form? — *Transplant carries specific risks and realistic outcome ranges that a generic surgical consent doesn't address.*

Evidence: Transplant-specific consent content

3. Is the recipient's understanding genuinely verified, not just a signature obtained? — *A signature confirms a form was signed, not that the content was genuinely understood.*

Evidence: Understanding verification record

COMMON REASONS FOR A PARTIAL ANSWER

- **Consent covers transplant content but understanding isn't actively verified.**
- **Eligibility evaluation happens but isn't clearly documented separately from referral.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a documented eligibility evaluation process.
Week 2	Build transplant-specific consent content.
Week 3	Build an understanding-verification step into the consent process.
Ongoing	Spot-check recipient files for complete documentation.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Recipient file review	Checks for documented eligibility evaluation and transplant-specific consent with understanding verification.

EVIDENCE BASE

World Health Organization. WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation. Geneva: WHO; 2010 (updated 2024).

12.5 Organ and Tissue Traceability, End to End CORE

Every organ or tissue is traceable through a documented chain of custody from donor to recipient, including handling, testing, and transport, with no gap in the record at any point in that chain.

In plain terms: Every organ or tissue can genuinely be traced, start to finish, with no missing link anywhere in the chain — retrievable on request, not just theoretically documented.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A single gap anywhere in the chain of custody — at handling, testing, or transport — undermines the entire purpose of traceability, since the whole value lies in being able to reconstruct the complete path with confidence. A general pass/fail log entry for testing and screening, rather than specific, retrievable results tied to that particular organ or tissue, provides considerably less genuine assurance than a detailed, organ-specific record.

WHAT GOOD LOOKS LIKE

- A continuous chain of custody record exists with no gap at any handling point.
- Specific testing and screening results are included, not a general log entry.

COMMON FAILURE MODES

- A gap exists in the record at one or more handling points.
- Testing records are a general pass/fail note rather than specific results.
- The chain is theoretically documented but difficult to

- The full chain can genuinely be reconstructed on request for a specific organ.

actually reconstruct.

WORKED EXAMPLE

IN PRACTICE

A tissue bank reviewing its traceability record completeness.

BEFORE	An attempt to reconstruct a specific tissue's full chain of custody revealed a gap during the transport handoff between the recovery team and the processing lab, where no formal handoff record had been kept.
ACTION	The tissue bank built a mandatory handoff record at every transfer point in the chain, with a barcode or equivalent tracking system ensuring no point in the process lacks a documented record.
AFTER	The Monitor selected a specific tissue and successfully reconstructed its complete chain of custody from donor through to recipient, with no gap at any point. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Attempt to reconstruct a specific organ or tissue's full chain right now.
2. Identify any gap points in the current process.
3. Build a mandatory handoff record at every transfer point.

The most common mistake: A gap in the documented chain at a specific transfer point — often between teams or facilities — where no formal handoff record was kept, discovered only when someone actually attempts to reconstruct the full chain.

SELF-ASSESSMENT QUESTIONS

1. Is there an actual, continuous chain of custody record, with no gap at any handling point? — *A single gap in the chain undermines the*

entire traceability purpose.
Evidence: Chain of custody record

2. Does the record include testing and screening results specific to that organ or tissue, not just a general log entry? — *Specific, retrievable results, not a generic pass/fail note.*
Evidence: Organ-specific testing record

3. Can the full chain be reconstructed on request for a specific organ or tissue? — *Genuinely retrievable on demand, not theoretically traceable but practically difficult to reconstruct.*
Evidence: Live reconstruction exercise

COMMON REASONS FOR A PARTIAL ANSWER

- Most points are documented but one specific transfer point lacks a record.
- Records exist but take considerable effort to actually reconstruct.

IMPLEMENTATION PLAN

When	What
Week 1	Attempt to reconstruct a current chain and identify any gaps.
Week 2	Build a mandatory handoff record at every transfer point.
Week 3	Build or confirm a tracking system enabling quick reconstruction.
Ongoing	Periodically test reconstruction speed and completeness.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Live chain reconstruction	Selects a specific organ or tissue and attempts to reconstruct its full chain of custody on the spot.

EVIDENCE BASE

World Health Organization. WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation. Geneva: WHO; 2010 (updated 2024).

12.6 Post-Transplant Follow-Up and Outcome Tracking

STANDARD

Transplant recipients are followed systematically after the procedure, with graft and patient outcomes tracked and reported, not lost to follow-up once the recipient is discharged from the immediate post-operative period.

In plain terms: Recipients are genuinely followed on a real schedule, with outcomes tracked across the whole program — not simply relying on the recipient to reach out if something's wrong.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Relying on a recipient's own initiative to seek follow-up, rather than a proactive, systematic schedule, risks losing track of patients precisely when ongoing monitoring for rejection or complications matters most. Outcomes scattered across individual, unconnected patient files, rather than genuinely aggregated and tracked, prevent the program from meaningfully monitoring its own overall performance over time — a capability that matters both for quality improvement and for honest accountability.

WHAT GOOD LOOKS LIKE

- A documented, systematic follow-up schedule exists, not informal recipient-initiated contact.
- Graft and patient outcomes are actually tracked and aggregated.
- A documented process exists for re-engaging a recipient lost to follow-up.

COMMON FAILURE MODES

- Follow-up depends on the recipient reaching out, not a proactive schedule.
- Outcomes exist in individual files but aren't aggregated for program-level tracking.
- A recipient lost to follow-up is simply accepted, with no active re-engagement.

WORKED EXAMPLE

IN PRACTICE

A transplant program reviewing its follow-up completeness.

BEFORE	Follow-up largely depended on recipients scheduling their own appointments, with no proactive outreach, and graft outcome data existed scattered across individual patient charts with no program-level aggregation or tracking.
ACTION	The program built a proactive follow-up schedule with automated reminders, an aggregated outcome tracking database, and a specific re-engagement protocol — including a direct outreach call — for any recipient who misses a scheduled follow-up.
AFTER	The Monitor reviewed the aggregated outcome database and confirmed a recent re-engagement case where a missed follow-up triggered a successful outreach call bringing the recipient back into care. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a proactive, systematic follow-up schedule, not recipient-initiated contact.
2. Build an aggregated outcome tracking system across the program.
3. Build a specific re-engagement protocol for missed follow-ups.

The most common mistake: Relying on recipients to schedule their own follow-up appointments rather than a proactive, systematic schedule, which risks losing track of patients precisely when ongoing monitoring matters most.

SELF-ASSESSMENT QUESTIONS

1. Is there a documented, systematic follow-up schedule, not informal contact depending on the recipient's own initiative? — A *real, proactive schedule, not reliance on the recipient to seek follow-up*

themselves.
Evidence: Follow-up schedule

2. Are graft and patient outcomes actually tracked and aggregated, not scattered across individual, unconnected patient files? —
Aggregated tracking enables the program to genuinely monitor its own outcomes over time.
Evidence: Aggregated outcome database

3. Is there a documented process for what happens when a recipient is lost to follow-up? — *A specific, active process for re-engagement, not simply accepting the loss.*
Evidence: Re-engagement protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **A follow-up schedule exists but outcomes aren’t aggregated at a program level.**
- **No active re-engagement process exists for recipients who miss follow-up.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a proactive follow-up schedule.
Week 2	Build an aggregated outcome tracking system.
Week 3	Build a re-engagement protocol for missed follow-ups.
Ongoing	Review program-level outcome trends periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Outcome database review	Checks the aggregated outcome tracking system and reviews a specific missed-follow-up re-engagement case.

EVIDENCE BASE

World Health Organization. WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation. Geneva: WHO; 2010 (updated 2024).

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← **Standard 11 — Critical Care**

Standard 13 — Radiology →

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Standard 13 — Radiology

6 criteria · 3 non-negotiable · 2 core · 1 standard-level · Version 1.0

CRITERIA IN THIS STANDARD

- 13.1 — Radiation Dose Optimization and Justification
- 13.2 — Equipment Quality Assurance and Calibration
- 13.3 — Timely, Accurate Reporting with Critical Finding Escalation
- 13.4 — Contrast Media Safety Protocol
- 13.5 — MRI Safety Screening and Zone Control
- 13.6 — Image and Report Retention, Accessible for Comparison

13.1 Radiation Dose Optimization and Justification

NON-NEGOTIABLE

Every imaging study involving ionizing radiation is clinically justified before ordering, with dose optimized to the lowest level consistent with diagnostic quality, not a default protocol applied regardless of patient size, age, or clinical indication.

In plain terms: Every scan involving radiation has a real clinical reason behind it, and the dose is genuinely tailored to the patient — not a one-size-fits-all setting applied regardless of who’s actually being scanned.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A placed order is not the same thing as documented clinical justification — the distinction matters because justification is the step that genuinely weighs the diagnostic benefit against the radiation risk for this specific patient and situation. A pediatric patient given an adult-dose protocol receives meaningfully excess radiation exposure relative to their smaller body size, which is why age- and size-adjusted protocols are a specific, checkable safeguard rather than a general good practice statement.

WHAT GOOD LOOKS LIKE

- Clinical justification is actually documented before the study, not assumed from the order.
- Dose protocols are genuinely adjusted for patient size and age.
- Actual delivered dose is tracked and reviewable.

COMMON FAILURE MODES

- An order is treated as equivalent to documented clinical justification.
- A single adult-dose protocol is applied regardless of patient size or age.
- Dose tracking relies on the intended protocol setting, not verified actual delivery.

WORKED EXAMPLE

IN PRACTICE

A radiology department reviewing its pediatric imaging practice.

BEFORE

CT studies were performed using a single standard adult protocol regardless of patient age, meaning pediatric patients received meaningfully higher radiation exposure relative to their body size than clinically necessary.

ACTION

The department built age- and weight-adjusted dose protocols specifically for pediatric patients, with a required clinical justification field

completed before any study is performed, and a dose tracking system logging actual delivered dose per study.

AFTER

The Monitor reviewed recent pediatric studies and found age-adjusted protocols applied with documented justification and tracked actual dose for each. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether current protocols are adjusted for patient age and size.
2. Build age- and weight-adjusted protocols, particularly for pediatric patients.
3. Build a required clinical justification field and an actual dose tracking system.

The most common mistake: Applying a single standard adult imaging protocol regardless of the patient's actual age or size, which results in meaningfully excess radiation exposure for smaller or pediatric patients relative to what's clinically necessary.

SELF-ASSESSMENT QUESTIONS

1. Is clinical justification actually documented before the study is performed, not assumed from the order alone? — *An order placed is not the same as a documented clinical justification for that specific radiation exposure.*

Evidence: Justification record

2. Are dose protocols adjusted for patient size and age, particularly for pediatric patients, not a single adult default applied to everyone? — *A pediatric patient given an adult-dose protocol receives meaningfully excess radiation exposure.*

Evidence: Age/weight-adjusted protocol documentation

3. Is actual delivered dose tracked and reviewable, not just the protocol setting assumed to reflect what was delivered? — *Verified against actual dose records, not only the intended protocol.*

Evidence: Dose tracking log

COMMON REASONS FOR A PARTIAL ANSWER

- Justification is documented inconsistently, not for every study.
- Pediatric protocols exist but aren't consistently applied.

IMPLEMENTATION PLAN

When	What
Week 1	Audit current dose protocol practice for age/size adjustment.
Week 2	Build age- and weight-adjusted protocols.
Week 3	Build a required justification field and dose tracking system.
Ongoing	Review dose tracking data periodically for outliers.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Dose protocol and justification review	Checks recent pediatric and adult studies for appropriately adjusted protocols and documented justification.

EVIDENCE BASE

International Atomic Energy Agency. Radiation Protection and Safety in Medical Uses of Ionizing Radiation. Vienna: IAEA; 2018.

World Health Organization. Communicating Radiation Risks in Paediatric Imaging. Geneva: WHO; 2016.

13.2 Equipment Quality Assurance and Calibration

NON-NEGOTIABLE

All imaging equipment undergoes documented quality assurance testing and calibration on a defined schedule by qualified personnel, with any equipment failing to meet standards immediately removed from clinical use until corrected.

In plain terms: Every imaging machine is genuinely tested and calibrated on a real schedule by someone actually qualified to do it — and if it fails, it stops being used immediately, not kept running while a fix is arranged.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A testing schedule that exists on paper but is routinely missed in practice offers no real protection — the genuine safeguard is a schedule that actually functions, verified against real completion records. Continuing to use equipment known to be out of calibration, while awaiting repair, is a specific and direct patient safety risk, since diagnostic accuracy and radiation dose accuracy both depend on properly calibrated equipment.

WHAT GOOD LOOKS LIKE

- Quality assurance testing is actually performed on schedule, verified against records.
- Equipment failing standards is immediately removed from clinical use.
- Testing is performed by genuinely qualified, verifiable personnel.

COMMON FAILURE MODES

- A testing schedule exists but is routinely missed or delayed.
- Equipment known to be out of calibration stays in service while awaiting repair.
- Testing is done informally by whoever is available, not specifically qualified staff.

WORKED EXAMPLE

IN PRACTICE

A department discovering a mammography unit outside calibration tolerance.

BEFORE	Routine testing revealed a mammography unit was outside acceptable calibration tolerance, but the unit remained in clinical use for an additional two weeks while awaiting a service technician, since no backup unit was readily available.
ACTION	The department built a hard rule immediately removing any failing equipment from clinical use, with a backup equipment arrangement or referral pathway to a partner facility built in for exactly this situation.
AFTER	The Monitor reviewed a subsequent calibration failure and found the equipment immediately taken out of service, with patients redirected to a partner facility until repair was completed. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check current testing completion records against the required schedule.
2. Build a hard rule for immediate removal of failing equipment.
3. Arrange a backup equipment or referral pathway for exactly this situation.

The most common mistake: Keeping equipment known to be outside calibration tolerance in clinical use while awaiting repair, because no backup arrangement exists, rather than treating the removal as a genuine hard stop.

SELF-ASSESSMENT QUESTIONS

1. Is quality assurance testing actually performed on schedule, verified against real completion records, not just a schedule that exists on paper? — *A testing schedule that's routinely missed is not functioning.*

Evidence: Testing completion log

2. Is equipment failing quality standards immediately removed from clinical use, not kept in service while awaiting repair? — *Continued use of equipment known to be out of calibration is a specific, direct*

patient safety risk.

Evidence: Equipment removal record

3. Is testing performed by genuinely qualified personnel, verifiable through credentials, not informally by whoever is available? —

Quality assurance testing requires specific technical qualification, not general staff availability.

Evidence: Tester credential verification

COMMON REASONS FOR A PARTIAL ANSWER

- Testing happens but is occasionally delayed past the scheduled date.
- No backup arrangement exists for when equipment must be removed.

IMPLEMENTATION PLAN

When	What
Week 1	Audit current testing completion against the schedule.
Week 2	Build a hard removal rule for failing equipment.
Week 3	Arrange a backup equipment or referral pathway.
Ongoing	Track testing schedule adherence and any removal events.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Testing record review	Checks quality assurance completion records against the required schedule and any equipment removal events.

EVIDENCE BASE

International Atomic Energy Agency. Radiation Protection and Safety in Medical Uses of Ionizing Radiation. Vienna: IAEA; 2018.

13.3 Timely, Accurate Reporting with Critical Finding Escalation

NON-NEGOTIABLE

Imaging studies are reported within a defined time frame appropriate to clinical urgency, with a documented, genuinely functioning critical finding communication protocol ensuring an urgent result reaches the ordering clinician directly, not left in a queue for routine review.

In plain terms: Reports go out within a real, tracked timeframe, and a critical finding genuinely reaches the ordering clinician directly — not sitting in a routine queue where it could go unnoticed.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A general sense that reports “go out quickly enough” is considerably less reliable than actual tracked turnaround data against a defined target — perception and reality can diverge meaningfully without active measurement. A critical finding left in the standard reporting queue, awaiting routine review rather than triggering direct, immediate communication, can go unnoticed for a dangerously long period precisely when urgent action is needed.

WHAT GOOD LOOKS LIKE

- Reporting turnaround time is actually tracked and meeting defined targets.
- A critical finding triggers genuine, direct, documented communication, not a routine queue entry.
- A documented instance exists of the critical finding protocol actually being used.

COMMON FAILURE MODES

- Turnaround time is assumed adequate without actual tracking.
- A critical finding is entered into the standard queue rather than directly communicated.
- No example exists of the critical finding protocol ever actually being used.

WORKED EXAMPLE

IN PRACTICE

A radiologist identifying an unexpected critical finding during a routine study.

BEFORE	An unexpected critical finding was entered into the standard reporting system, which the ordering physician would see once they next checked their results queue, with no direct notification sent, risking a significant delay before the finding was actually seen.
ACTION	The department built a mandatory direct-call protocol for any critical finding, requiring the radiologist to personally reach the ordering clinician or a covering provider, documented with the time of notification.
AFTER	The Monitor reviewed a recent critical finding record showing a direct call made and documented within minutes of the finding being identified. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a mandatory direct-communication protocol for critical findings.
2. Build a turnaround time tracking system against defined targets.
3. Check whether a real instance of the critical finding protocol exists.

The most common mistake: Entering a critical finding into the standard reporting queue, where the ordering physician would see it only when they next happen to check, rather than triggering immediate, direct, documented communication.

SELF-ASSESSMENT QUESTIONS

1. Is reporting turnaround time actually tracked and meeting defined targets, not assumed to be adequate? — *Verified against real turnaround data, not a general sense that reports “go out quickly*

enough.”

Evidence: Turnaround time tracking data

2. Does a critical finding trigger genuine, direct, documented communication to the ordering clinician, not just entered into the standard reporting queue? — *A critical finding left in a routine queue can go unnoticed for a dangerously long period.*

Evidence: Critical finding protocol

3. Is there a documented instance of the critical finding protocol actually being used? — *Evidence the protocol genuinely functions, not just exists on paper.*

Evidence: Critical finding notification record

COMMON REASONS FOR A PARTIAL ANSWER

- Turnaround tracking exists but isn’t actively reviewed against targets.
- A critical finding protocol exists but has never actually been used or tested.

IMPLEMENTATION PLAN

When	What
Week 1	Build a turnaround time tracking system.
Week 2	Build a mandatory direct-communication protocol for critical findings.
Week 3	Brief all radiology staff on the critical finding protocol.
Ongoing	Review turnaround data and any critical finding events periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Critical finding record review	Reviews turnaround time data and a specific critical finding notification record for direct, documented communication.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer. Geneva: WHO; 2021.

A written protocol governs contrast media use, including pre-screening for allergy and renal function, informed consent, and a documented, immediately accessible emergency response plan for a contrast reaction — not a generic allergy question treated as sufficient screening.

In plain terms: Contrast safety screening genuinely covers both allergy and kidney function, and emergency response equipment for a reaction is right there, ready to go — not a quick allergy question treated as the whole check.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A generic “any allergies?” question, while useful, doesn’t specifically address renal function, which matters distinctly for contrast safety and is easy to overlook without a dedicated check — treating allergy screening as the whole safety picture misses a real, checkable gap. A contrast reaction can develop rapidly, which is why emergency response equipment and medication genuinely need to be immediately accessible at the point of care, not stored elsewhere requiring retrieval time that could matter in a fast-developing reaction.

WHAT GOOD LOOKS LIKE

- Pre-screening genuinely covers both allergy history and renal function.
- Emergency response equipment is immediately accessible at the point of care.
- Staff are drilled on the emergency response

COMMON FAILURE MODES

- Screening covers allergy but not renal function specifically.
- Emergency response equipment is stored elsewhere, requiring retrieval time.
- Staff have read the protocol but have never actually drilled it.

protocol, not just given a reference document.

WORKED EXAMPLE

IN PRACTICE

A radiology department reviewing its contrast screening practice.

BEFORE	Pre-screening consisted of a general allergy question with no specific renal function check, and emergency response medication for a contrast reaction was stored in a central pharmacy requiring a several-minute retrieval during an actual event.
ACTION	The department built a specific renal function screening step into pre-contrast workup, and relocated emergency response medication to a dedicated, immediately accessible cart within the imaging suite, with a quarterly drill schedule.
AFTER	The Monitor confirmed renal function screening was documented for recent contrast studies, found emergency equipment immediately accessible, and reviewed a recent drill record. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a specific renal function screening step, not just a general allergy question.
2. Relocate emergency response equipment to be immediately accessible at the point of care.
3. Build a regular drill schedule for the emergency response protocol.

The most common mistake: Treating a general allergy question as sufficient pre-contrast screening, without a specific renal function check, and storing emergency response equipment somewhere that requires meaningful retrieval time during an actual fast-developing reaction.

SELF-ASSESSMENT QUESTIONS

1. Does pre-screening genuinely cover both allergy history and renal function, not a generic “any allergies?” question alone? — *Renal function specifically matters for contrast safety and is easy to overlook without a specific check.*

Evidence: Pre-screening record

2. Is emergency response equipment and medication for a contrast reaction immediately accessible at the point of care, not stored elsewhere requiring retrieval time? — *A contrast reaction can develop rapidly; retrieval delay for emergency response equipment is a specific, direct risk.*

Evidence: Equipment location inspection

3. Are staff drilled on the emergency response protocol, not only given it as a reference document? — *A drilled response functions differently under real stress than one only read about.*

Evidence: Drill record

COMMON REASONS FOR A PARTIAL ANSWER

- **Screening covers allergy but renal function checking is inconsistent.**
- **Emergency equipment is nearby but not genuinely immediately accessible.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a specific renal function screening step.
Week 2	Relocate emergency response equipment to immediate point-of-care access.
Week 3	Run an initial emergency response drill.
Ongoing	Repeat drills on a regular schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Point-of-care inspection	Confirms emergency response equipment accessibility and checks recent pre-screening records.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer. Geneva: WHO; 2021.

13.5 MRI Safety Screening and Zone Control CORE

Every patient and accompanying individual is screened for MRI contraindications before entering the magnetic field, with physical zone control preventing unscreened access — not a screening form completed but not actually verified before entry.

In plain terms: Everyone, patient or accompanying person, is genuinely screened before entering the magnet room, with a real physical barrier preventing unscreened access — not just a form filled out somewhere earlier and a posted warning sign.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A screening form completed earlier in the process, but not actually verified at the point of entry into the magnet room, provides no genuine protection — the verification step itself is what actually prevents an unscreened person or metallic object from entering the field. A posted warning sign relies on an individual's own judgment and attention; a genuine physical barrier or access control is the real safeguard, and this distinction matters because MRI contraindication incidents, though rare, can be serious.

WHAT GOOD LOOKS LIKE

- Screening is genuinely verified at the point of entry, not just completed earlier.
- Physical zone control genuinely prevents

COMMON FAILURE MODES

- A screening form is completed but not re-verified at the magnet room entry.
- Access relies on a posted sign rather than a genuine

unscreened access, not just a posted sign.

- Accompanying individuals are also genuinely screened, not only the patient.

physical barrier.

- Accompanying family members or support persons aren't screened.

WORKED EXAMPLE

IN PRACTICE

A family member accompanying a pediatric patient for an MRI.

BEFORE	The patient's screening form was completed at intake, but when a parent accompanied the child into the scan room for comfort, the parent themselves had not been screened, relying only on a posted warning sign at the door.
ACTION	The department built a mandatory screening verification step at the magnet room door itself, covering any accompanying individual, with a physical access-controlled entry preventing anyone unscreened from proceeding.
AFTER	The Monitor observed the screening verification process at the magnet room entry and confirmed an accompanying parent was screened before entry. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a mandatory screening verification step at the magnet room entry itself.
2. Extend screening explicitly to any accompanying individual.
3. Build a genuine physical access control, not just a posted sign.

The most common mistake: Relying on a screening form completed earlier in the process, without a genuine re-verification step at the actual point of entry into the magnet room, and relying on a posted warning sign rather than a real physical access barrier.

SELF-ASSESSMENT QUESTIONS

1. Is screening genuinely verified before entry into the magnet room, not just a form completed somewhere earlier in the process? — *A completed form that isn't actually checked at the point of entry provides no real protection.*

Evidence: Entry verification process

2. Does physical zone control genuinely prevent unscreened individuals from entering, not relying solely on a sign or verbal instruction? — *A physical barrier or access control, not just a posted warning, is the genuine safeguard.*

Evidence: Zone control inspection

3. Are accompanying individuals — not just the patient — also genuinely screened? — *A family member or support person entering unscreened carries the same risk as an unscreened patient.*

Evidence: Accompanying-individual screening record

COMMON REASONS FOR A PARTIAL ANSWER

- **Patients are screened but accompanying individuals sometimes aren't.**
- **Zone control relies more on signage than a genuine physical barrier.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current screening verification practice at point of entry.
Week 2	Build a mandatory entry-point verification step covering accompanying individuals.
Week 3	Build or confirm a genuine physical access control.
Ongoing	Observe entry practice periodically for consistency.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Entry point observation	Observes the screening verification process and physical access control at the magnet room entry.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer. Geneva: WHO; 2021.

13.6

Image and Report Retention,
Accessible for Comparison

STANDARD

Imaging studies and reports are retained per the required retention period and genuinely retrievable for comparison with prior studies, not archived in a way that makes practical retrieval difficult or unreliable.

In plain terms: Old studies are genuinely easy to pull up for comparison, not technically retained but practically a hassle to actually retrieve — and there’s real backup protection against data loss.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A comparison that’s technically possible but practically cumbersome enough to discourage actually doing it defeats the real clinical purpose of retention — comparison with prior studies is often genuinely significant for detecting subtle change over time, and friction in retrieval directly undermines whether that comparison actually happens in practice. A single point of failure in image storage, with no backup or redundancy, is a specific and serious risk given how much clinical history can be lost at once if that single system fails.

WHAT GOOD LOOKS LIKE

- Prior studies are genuinely, quickly retrievable for comparison.
- The retention period is actually met and verifiable against real retrieval.

COMMON FAILURE MODES

- Retrieval is technically possible but cumbersome enough to discourage actual use.
- The retention period is stated but not verified through actual older-study retrieval.

- A documented backup or redundancy process protects against data loss.

- No backup or redundancy protects against a single point of storage failure.

WORKED EXAMPLE

IN PRACTICE

A radiologist needing to compare a current study against one from three years prior.

BEFORE

Retrieving a study older than one year required a manual request to a separate archive system with a multi-day turnaround, which in practice meant radiologists rarely bothered requesting older comparisons even when clinically relevant.

ACTION

The department upgraded its archiving system to keep the full required retention period immediately accessible within the standard viewing system, eliminating the separate manual request step, alongside a redundant off-site backup.

AFTER

The Monitor tested retrieval of a three-year-old study and found it immediately accessible within the standard system, with the backup system confirmed functional. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Test actual retrieval time for an older study right now.
2. Build or upgrade archiving to keep the full retention period immediately accessible.
3. Build a redundant backup system.

The most common mistake: An archiving system that technically retains studies for the required period but makes older-study retrieval cumbersome enough, through a separate manual process, that radiologists in practice rarely bother requesting a clinically relevant comparison.

SELF-ASSESSMENT QUESTIONS

1. Are prior studies genuinely, quickly retrievable for comparison, not a retrieval process that's cumbersome enough to discourage actually checking? — *A comparison that's technically possible but practically avoided due to friction defeats the purpose.*

Evidence: Retrieval time test

2. Is the retention period actually met and verifiable, not assumed from a general archiving practice? — *Verified against actual retrieval of an older study, not just a stated retention policy.*

Evidence: Older-study retrieval test

3. Is there a documented backup or redundancy process protecting against data loss? — *A single point of failure in image storage is a specific, serious risk.*

Evidence: Backup system documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Studies are retained but retrieval beyond a recent window is cumbersome.**
- **No genuine redundancy exists beyond the primary storage system.**

IMPLEMENTATION PLAN

When	What
Week 1	Test current retrieval time for a study beyond the recent window.
Week 2	Build or upgrade archiving for immediate full-period accessibility.
Week 3	Build a redundant backup system.
Ongoing	Periodically test retrieval and backup system functionality.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Retrieval test	Tests retrieval of a study near the end of the required retention period and confirms backup system function.

EVIDENCE BASE

International Atomic Energy Agency. Radiation Protection and Safety in Medical Uses of Ionizing Radiation. Vienna: IAEA; 2018.

← **Hospital Standards — all standards**

Self-assess against these criteria →

← **Standard 12 — Organ & Tissue Transplant**

Standard 14 — Oncology & Cancer Care →

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Standard 14 — Oncology & Cancer Care

6 criteria · 3 non-negotiable · 2 core · 1 standard-level · Version 1.0

CRITERIA IN THIS STANDARD

- 14.1 — Cytotoxic Drug Handling Follows a Verified Safe-Handling Standard
- 14.2 — Chemotherapy Dose Is Verified by Independent Two-Person Check
- 14.3 — Neutropenic Fever Triggers an Immediate, Time-Bound Response
- 14.4 — Extravasation Is Recognised and Managed Immediately
- 14.5 — Multidisciplinary Tumor Board Informs Treatment Planning
- 14.6 — Palliative Care Integrated Alongside Active Treatment

14.1 Cytotoxic Drug Handling Follows a Verified Safe-Handling Standard

NON-NEGOTIABLE

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

member, including on inpatient wards where chemotherapy may be administered outside the dedicated infusion unit.

In plain terms: Cytotoxic drugs are handled safely and consistently everywhere they're actually used in the hospital — not just in the dedicated oncology unit, with ward nurses left to improvise.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A hospital's chemotherapy safe-handling practice can look solid in the dedicated oncology or infusion unit, while quietly breaking down the moment a patient receiving chemotherapy is on a general ward — for a complication, a combined admission, or simply overflow capacity — and ward nursing staff who handle it only occasionally lack the specific, consistent training and equipment access that unit-based staff take for granted. This gap is precisely what this criterion is built to catch, since hazardous drug exposure risk doesn't diminish just because the drug is being given somewhere other than the usual unit.

WHAT GOOD LOOKS LIKE

- PPE is used consistently by ward staff, not only the dedicated infusion unit.
- Required engineering controls are used wherever preparation actually happens.
- A compliant hazardous waste pathway exists on every unit where it's generated.

COMMON FAILURE MODES

- Safe handling is strong in the oncology unit but weak on general wards.
- Ward staff lack specific training or ready access to required PPE.
- Hazardous waste from off-unit administration goes into general medical waste.

WORKED EXAMPLE

IN PRACTICE

A patient receiving chemotherapy while admitted to a general medical ward for an unrelated infection.

BEFORE	The oncology unit's safe-handling practice was excellent, but when this patient's scheduled chemotherapy was given on the general ward to avoid transfer, the ward nurses had never received chemotherapy-specific handling training and used standard gloves rather than chemotherapy-rated PPE.
ACTION	The hospital built mandatory chemotherapy safe-handling training for all nursing staff, not just the oncology unit, with PPE and disposal supplies stocked on every ward with a defined protocol for exactly this off-unit administration scenario.
AFTER	The Monitor reviewed a subsequent off-unit administration and found ward staff using correct PPE with documented training completion. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether chemotherapy is ever administered outside the dedicated unit.
2. Extend safe-handling training to all relevant nursing staff, not only the oncology unit.
3. Stock required PPE and disposal supplies on any unit where off-unit administration occurs.

The most common mistake: Strong safe-handling practice in the dedicated oncology unit that quietly breaks down whenever chemotherapy needs to be administered on a general ward, where staff lack the same specific training and equipment access.

SELF-ASSESSMENT QUESTIONS

1. Is appropriate personal protective equipment used consistently for every stage of handling, including by inpatient ward nursing staff, not only dedicated infusion unit staff? — *Consistent use at every stage and location, not only in the specialized infusion setting.*
Evidence: PPE usage observation and training records

2. Are hazardous drugs prepared and stored using the required engineering controls, not standard pharmacy equipment? — *Specific,*

required controls, not general pharmacy practice assumed to be sufficient.

Evidence: Pharmacy preparation area inspection

3. Is hazardous waste disposed of through a defined, compliant pathway on every inpatient unit where it's generated, not general medical waste? — *A specific, separate disposal pathway matched to the actual risk, available wherever cytotoxic agents are actually used.*

Evidence: Waste disposal record

COMMON REASONS FOR A PARTIAL ANSWER

- Training and supplies are strong in the oncology unit but inconsistent on general wards.
- No specific protocol exists for off-unit chemotherapy administration scenarios.

IMPLEMENTATION PLAN

When	What
Week 1	Check whether off-unit chemotherapy administration occurs.
Week 2	Extend safe-handling training hospital-wide for relevant staff.
Week 3	Stock required PPE and disposal supplies on relevant units.
Ongoing	Spot-check any off-unit administration for consistent safe practice.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Multi-unit inspection	Observes safe-handling practice both in the dedicated unit and on a general ward if off-unit administration occurs.

EVIDENCE BASE

World Health Organization. WHO Guidelines on Hand Hygiene and Hazardous Drug Handling in Health Care. Geneva: WHO; 2019.

14.2 Chemotherapy Dose Is Verified by Independent Two-Person Check

Every chemotherapy dose, drug, route, and infusion rate is independently verified by two qualified individuals before administration, each forming their own judgement separately — not a single check followed by a second signature, and applied identically on inpatient wards as in the dedicated oncology unit.

In plain terms: Every chemotherapy dose is genuinely double-checked by two people working independently — not one person checking and a second just signing off — wherever in the hospital it's actually given.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A second signature that simply confirms the first person's already-formed conclusion provides considerably less genuine protection than two people independently forming their own judgement from the original order — the entire value of a double-check lies in two genuinely separate assessments, not a sequential rubber stamp. This matters identically regardless of which unit the chemotherapy happens to be given on; an exception made for “perceived routine” cases, or for administration outside the usual oncology unit, undermines the safeguard precisely where consistency matters most.

WHAT GOOD LOOKS LIKE

- Every dose undergoes genuine independent verification by two qualified individuals.
- Each person forms their own separate judgement, not a confirmatory signature.
- Verification covers drug, dose, route, and infusion

COMMON FAILURE MODES

- A “routine” case is exempted from full independent double-checking.
- The second check is a signature confirming the first, not a genuine separate assessment.
- Verification covers dose alone, missing route or

rate together.

rate errors.

WORKED EXAMPLE

IN PRACTICE

A hospital reviewing its double-check practice across units.

BEFORE

In the dedicated oncology unit, two nurses genuinely independently calculated and verified each dose. On the general ward, where chemotherapy was occasionally given, one nurse calculated the dose and a second simply co-signed without independently recalculating.

ACTION

The hospital standardized the independent verification process hospital-wide, requiring both verifiers to calculate independently from the original order before comparing results, with training extended to any staff who might administer chemotherapy off-unit.

AFTER

The Monitor observed a general ward chemotherapy administration and confirmed both nurses performed genuinely independent calculations before comparing. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether double-checking is genuinely independent or a confirmatory signature.
2. Build a process requiring independent calculation before comparison.
3. Standardize this process identically across every unit where chemotherapy is given.

The most common mistake: A genuine independent double-check in the dedicated oncology unit that degrades into a confirmatory signature on a general ward, where the second verifier simply co-signs rather than independently recalculating from the original order.

SELF-ASSESSMENT QUESTIONS

1. Does every chemotherapy dose undergo independent verification by two qualified individuals before administration, on every unit where it's given? — *Two people, every dose, without exception for perceived routine cases or off-unit administration.*

Evidence: Verification record

2. Does each person form their own separate judgement, not simply confirm the first person's check? — *Genuine independence, not sequential confirmation of the same conclusion.*

Evidence: Direct observation of the verification process

3. Does verification specifically cover drug, dose, route, and infusion rate together, not dose alone? — *All four elements, since an error in any one carries real risk.*

Evidence: Verification checklist content

COMMON REASONS FOR A PARTIAL ANSWER

- Independent verification is strong on the dedicated unit but weaker on general wards.
- Verification covers dose but not consistently route and rate.

IMPLEMENTATION PLAN

When	What
Week 1	Observe current double-check practice across relevant units.
Week 2	Build a standardized independent-verification process.
Week 3	Train all relevant staff hospital-wide.
Ongoing	Observe verification practice periodically for genuine independence.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Direct verification observation	Observes an actual chemotherapy double-check for genuine independence versus confirmatory signature.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer.
Geneva: WHO; 2021.

14.3 **Neutropenic Fever Triggers an Immediate, Time-Bound Response**

NON-NEGOTIABLE

A patient with suspected neutropenic fever receives first-dose antibiotics within a defined, short time target from presentation, with staff trained to recognize the urgency and a protocol that bypasses routine triage queuing — not treated as a standard fever presentation.

In plain terms: Neutropenic fever genuinely gets treated as the time-critical emergency it is — with antibiotics started fast and real tracking of how fast — not quietly treated as just another fever in the queue.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Neutropenic fever carries a specific, well-documented time-sensitivity — delay in starting antibiotics measurably worsens outcomes, which is precisely why routine triage queuing, appropriate for a standard fever presentation, represents a genuine and preventable risk here. A general sense that treatment happens “promptly” is considerably less reliable than a specific, measured time target genuinely tracked against actual practice, since the gap between perceived and actual speed can be significant without active measurement.

WHAT GOOD LOOKS LIKE

- A specific, measured time target exists and is genuinely tracked.

COMMON FAILURE MODES

- Treatment speed is assumed adequate without a specific, tracked target.

- Staff recognize neutropenic fever as time-critical, bypassing standard queuing.
- A documented instance exists with actual time-to-antibiotic data recorded.
- A neutropenic fever patient waits in standard triage like any other fever.
- No real example exists showing actual measured time-to-antibiotic data.

WORKED EXAMPLE

IN PRACTICE

An oncology patient presenting to the emergency department with fever.

BEFORE	A patient on chemotherapy presenting with fever was triaged alongside other fever presentations without specific recognition of neutropenic fever risk, resulting in a wait time before antibiotics that significantly exceeded recommended targets.
ACTION	The hospital built a specific neutropenic fever alert triggered by any oncology patient presenting with fever, bypassing standard triage queuing and activating a dedicated rapid antibiotic pathway with a defined time target actively tracked.
AFTER	The Monitor reviewed time-to-antibiotic data for recent neutropenic fever presentations and found consistent achievement of the defined target. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Set a specific, defined time-to-antibiotic target.
2. Build a neutropenic fever alert bypassing standard triage queuing.
3. Build a tracking system for actual time-to-antibiotic data.

The most common mistake: Treating a febrile oncology patient as a routine fever presentation in standard triage, without recognizing the time-critical nature of possible neutropenic fever,

resulting in a wait time that significantly exceeds what the patient's actual risk warrants.

SELF-ASSESSMENT QUESTIONS

1. Is there a defined, specific time target for first-dose antibiotics from presentation, genuinely tracked against actual practice? — *A specific, measured target, not a general sense that treatment happens "promptly."*

Evidence: Time-to-antibiotic tracking data

2. Do staff recognize neutropenic fever as a time-critical emergency distinct from routine fever, bypassing standard queuing? — *Delay from routine triage treatment is a specific, well-documented risk for this patient population.*

Evidence: Alert/bypass protocol

3. Is there a documented instance of this protocol being used with actual time-to-antibiotic data recorded? — *Evidence the protocol genuinely functions, not just exists on paper.*

Evidence: Case record with timing data

COMMON REASONS FOR A PARTIAL ANSWER

- **A target exists but isn't consistently tracked against real cases.**
- **Recognition and bypass work in the emergency department but not consistently elsewhere.**

IMPLEMENTATION PLAN

When	What
Week 1	Set a specific time-to-antibiotic target.
Week 2	Build a neutropenic fever alert and triage-bypass protocol.
Week 3	Build a time-tracking system and brief relevant staff.
Ongoing	Review time-to-antibiotic data periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Time-to-antibiotic data review	Reviews actual recorded time-to-antibiotic data for recent neutropenic fever presentations against the defined target.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer. Geneva: WHO; 2021.

14.4 Extravasation Is Recognised and Managed Immediately CORE

Staff administering vesicant or irritant chemotherapy agents are specifically trained to recognise early signs of extravasation, with a defined, immediate management protocol and appropriate antidotes genuinely available wherever these agents are administered, including inpatient wards.

In plain terms: Staff genuinely know the early signs of extravasation for the specific drugs they're actually giving, and the right antidote is actually on hand wherever that drug is administered — not only in the dedicated unit.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Generic infusion complication awareness is distinct from specific, agent-relevant extravasation recognition — a vesicant agent causing tissue damage requires staff to know exactly what to look for with that particular drug, not a general sense that something might be wrong. If antidotes for a specific vesicant are available in the oncology unit but

the same agent is occasionally given on a general ward without matching antidote stock, that specific gap undermines the entire purpose of having the antidote protocol at all.

WHAT GOOD LOOKS LIKE

- Staff are trained on recognition specific to the actual agents used here.
- A defined management protocol is accessible on every unit where the agent is given.
- Appropriate antidotes are genuinely available wherever administration occurs.

COMMON FAILURE MODES

- Training covers general infusion complications, not agent-specific extravasation signs.
- The management protocol exists only in the dedicated unit's reference materials.
- Antidotes are stocked in the oncology unit but not wherever off-unit administration occurs.

WORKED EXAMPLE

IN PRACTICE

A vesicant agent administered on a general ward during an oncology patient's unrelated admission.

BEFORE

The specific antidote for this vesicant agent was stocked and readily accessible in the oncology unit, but when the same agent needed to be given on the general ward, the antidote wasn't stocked there, and ward staff weren't trained on this agent's specific early extravasation signs.

ACTION

The hospital built a protocol requiring the matching antidote to accompany any vesicant agent dispensed for off-unit administration, with a quick-reference card on agent-specific signs provided alongside the medication itself.

AFTER

The Monitor reviewed a subsequent off-unit administration and confirmed the matching antidote and reference card accompanied the medication to the ward. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether off-unit vesicant administration currently has matching antidote access.
2. Build a protocol pairing antidote dispensing with the agent itself.
3. Build agent-specific quick-reference materials for off-unit staff.

The most common mistake: Antidotes and agent-specific training being available in the dedicated oncology unit while the same vesicant agent, occasionally given on a general ward, lacks matching antidote stock and staff training in that other location.

SELF-ASSESSMENT QUESTIONS

1. Are staff specifically trained to recognise early signs of extravasation for the agents actually used here, including ward nursing staff? — *Specific to the actual agents administered, not generic infusion complication awareness.*

Evidence: Training record

2. Is there a defined, immediate management protocol for suspected extravasation accessible on every unit? — *A specific, known protocol, not improvisation in the moment, available wherever the agent might be given.*

Evidence: Accessible protocol documentation

3. Are appropriate antidotes for the specific vesicant agents used genuinely available wherever administration occurs? — *Immediately available and in date on the actual unit, not only in the dedicated oncology area.*

Evidence: Antidote stock inspection

COMMON REASONS FOR A PARTIAL ANSWER

- **Antidotes are stocked in the main unit but not consistently for off-unit administration.**
- **Training is agent-specific in the oncology unit but general elsewhere.**

IMPLEMENTATION PLAN

When	What
Week 1	Check current antidote access for off-unit administration scenarios.

When	What
Week 2	Build a protocol pairing antidote dispensing with the agent.
Week 3	Build agent-specific quick-reference materials for off-unit staff.
Ongoing	Spot-check off-unit administration for matching antidote access.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Antidote availability check	Checks antidote availability and matching agent-specific training wherever vesicant agents are actually administered.

EVIDENCE BASE

World Health Organization. Patient Safety: Make Health Care Safer. Geneva: WHO; 2021.

14.5 Multidisciplinary Tumor Board Informs Treatment Planning CORE

Complex or newly diagnosed cancer cases are genuinely reviewed by a multidisciplinary tumor board before the treatment plan is finalized, with documented board input actually shaping the plan, not a single treating physician's decision presented as though it were a team decision.

In plain terms: Complex cancer cases genuinely get real multidisciplinary review before the plan is finalized — with board input actually visible in the plan, not a formality rubber-stamping one physician's decision.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

A tumor board that meets on schedule but doesn't substantively engage with the specifics of each case — functioning more as a formality than genuine multidisciplinary deliberation — provides none of the real clinical value that comes from surgery, oncology, radiology, and pathology perspectives genuinely informing a complex treatment decision together. The test of whether a board is functioning is whether documented input can actually be traced to a specific change in the treatment plan, not merely whether the meeting occurred.

WHAT GOOD LOOKS LIKE

- The board meets regularly and genuinely reviews complex or new cases.
- Board input is documented as having actually shaped the treatment plan.
- The board genuinely includes relevant specialties, not token representation.

COMMON FAILURE MODES

- A board exists nominally without substantive case review in practice.
- Board attendance is noted but input isn't traceable to actual plan changes.
- One specialty dominates discussion with limited genuine input from others.

WORKED EXAMPLE

IN PRACTICE

A hospital reviewing its tumor board's genuine function.

BEFORE

The tumor board met weekly and cases were presented, but discussion was brief and the treating oncologist's pre-formed plan was typically approved with minimal substantive input from surgery, radiology, or pathology, functioning more as a notification than genuine deliberation.

ACTION

The hospital restructured board meetings to require pathology and radiology findings presented first, before the treating physician's proposed plan, specifically to encourage genuine discussion rather than confirmation of a pre-formed decision.

AFTER

The Monitor reviewed recent board minutes and found a specific instance where radiology findings discussed at the board changed the proposed surgical approach. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Observe a current tumor board meeting for genuine, substantive discussion.
2. Restructure presentation order to encourage discussion before plan confirmation.
3. Build a documentation practice tracing board input to specific plan changes.

The most common mistake: A tumor board that meets on a regular schedule and documents attendance, but functions in practice as a brief notification of an already-decided plan rather than genuine multidisciplinary deliberation that could actually change the proposed course.

SELF-ASSESSMENT QUESTIONS

1. Does a genuine multidisciplinary tumor board meet regularly and actually review complex or new cases, not exist nominally without real case review? — *A board that meets but doesn't substantively review actual cases provides no real value.*

Evidence: Board meeting minutes

2. Is board input documented as having actually shaped the treatment plan, not just noted as having occurred? — *A documented instance where discussion specifically changed the plan is a real test of genuine function.*

Evidence: Input-to-plan traceability

3. Does the board genuinely include relevant specialties — surgery, oncology, radiology, pathology — not a single specialty consulting nominally with others? — *Real multidisciplinary input, not one discipline dominating with token representation from others.*

Evidence: Attendance and participation record

COMMON REASONS FOR A PARTIAL ANSWER

- **The board meets with good attendance but discussion is brief and non-substantive.**

- Input is noted in minutes but not clearly traceable to actual plan changes.

IMPLEMENTATION PLAN

When	What
Week 1	Observe a current tumor board meeting for genuine engagement.
Week 2	Restructure presentation order to encourage discussion.
Week 3	Build a documentation practice tracing input to plan changes.
Ongoing	Review board minutes periodically for substantive discussion evidence.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Board meeting observation	Observes a tumor board meeting directly for genuine multidisciplinary engagement versus formality.

EVIDENCE BASE

World Health Organization. Guide to Cancer Early Diagnosis. Geneva: WHO; 2017.

14.6 Palliative Care Integrated Alongside Active Treatment

STANDARD

Palliative care expertise is genuinely integrated early in the course of serious cancer diagnoses, alongside active treatment, not introduced only once active treatment has been exhausted — with symptom management and goals-of-care conversations happening throughout, not as a late, separate referral.

In plain terms: Palliative care genuinely starts early, alongside active treatment, not held back until there's nothing more to try — with real, ongoing conversations

about what matters to the patient, not one late discussion.

Facility category	Crisis	Transitional	Small	Standard
Applicability	Where applicable	Full	Full	Full

WHY THIS MATTERS

Palliative care introduced only once active treatment options are exhausted misses the real, distinct benefit early integration provides — genuine symptom management and quality-of-life support that’s valuable throughout the treatment course, not only at its end. A single late goals-of-care conversation, held only once options have significantly narrowed, misses the ongoing value of these conversations happening at meaningful points throughout, when the patient and family have more genuine opportunity to process and participate in decisions.

WHAT GOOD LOOKS LIKE

- Palliative care is genuinely introduced early, alongside active treatment.
- Goals-of-care conversations happen at meaningful points throughout the course.
- Palliative referral is genuinely accessible and actually used.

COMMON FAILURE MODES

- Palliative care is introduced only once active treatment is exhausted.
- Goals-of-care conversations happen once, late, rather than ongoing.
- Palliative referral exists but is rarely actually used in practice.

WORKED EXAMPLE

IN PRACTICE

A patient with a serious new cancer diagnosis beginning active treatment.

BEFORE

Palliative care was mentioned only once active treatment options had been fully exhausted, framed to the patient as a sign that nothing more could be done, missing months of potential

	symptom management and quality-of-life support available earlier in the course.
ACTION	The hospital built a routine early palliative care consultation for any serious new cancer diagnosis, explicitly framed as support alongside active treatment, with scheduled goals-of-care check-ins at defined points throughout the course.
AFTER	The Monitor reviewed a recent patient's record and found an early palliative consultation documented alongside the start of active treatment, with ongoing goals-of-care conversations at subsequent points. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a routine early palliative care consultation trigger for serious diagnoses.
2. Explicitly frame palliative care as alongside, not after, active treatment.
3. Build scheduled goals-of-care check-in points throughout the course.

The most common mistake: Introducing palliative care only once active treatment options are fully exhausted, which misses the real, distinct value of early symptom management and quality-of-life support and can unintentionally frame the referral as a signal of abandoned hope rather than ongoing support.

SELF-ASSESSMENT QUESTIONS

1. Is palliative care genuinely introduced early, alongside active treatment, not only after active treatment options are exhausted? —
Early integration provides real symptom and quality-of-life benefit distinct from end-of-life care alone.

Evidence: Palliative consultation timing record

2. Are goals-of-care conversations happening at meaningful points throughout the course, not deferred to a single late conversation? —
Ongoing, not a one-time discussion held only when options have

narrowed.

Evidence: Goals-of-care conversation log

3. Is palliative referral genuinely accessible and actually used, not a resource that exists on paper but is rarely accessed? — *Verified against actual recent use, not only the existence of a palliative care service.*

Evidence: Referral usage data

COMMON REASONS FOR A PARTIAL ANSWER

- **Palliative care is available but introduced later than genuinely early.**
- **Goals-of-care conversations happen but not on a genuinely ongoing basis.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current palliative referral timing patterns.
Week 2	Build an early referral trigger for serious diagnoses.
Week 3	Build scheduled goals-of-care check-in points.
Ongoing	Review referral timing and usage data periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Referral timing review	Reviews palliative consultation timing relative to diagnosis and active treatment start for recent patients.

EVIDENCE BASE

World Health Organization. Palliative Care. Geneva: WHO; 2020.

← **Hospital Standards — all standards**

Self-assess against these criteria →

← **Standard 13 — Radiology**

**Standard 15 — Psychiatry &
Mental Health →**

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