

ASF STANDARDS · HOSPITAL · STANDARD 18

Standard 18 — Sustainable Care

7 criteria · 2 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 6, 6th Edition

CRITERIA IN THIS STANDARD

- 18.1 — Environmental Impact Is Actually Reviewed at Strategic Level
- 18.2 — Staff and Patients Are Genuinely Informed of Sustainability Goals
- 18.3 — Sustainability Progress Is Actually Reported to Governance
- 18.4 — Procurement Genuinely Considers Responsible Stewardship of Resources
- 18.5 — Energy Use Is Monitored, With a Genuine Move Toward Renewable Sources
- 18.6 — A Genuine Carbon Footprint Baseline Exists
- 18.7 — The Hospital Genuinely Plans for Environmental and Climate Resilience

18.1

Environmental Impact Is Actually Reviewed at Strategic Level

STANDARD

Hospital leadership undertakes a genuine, strategic-level review of the facility’s environmental impact and the sustainability of how it delivers care — not an assumption

or a problem for another department.

In plain terms: Someone at the top of the hospital has actually sat down and worked out what the hospital's real environmental footprint is and where it comes from — not left this as a topic nobody in leadership has ever formally addressed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A hospital that has never formally reviewed its environmental impact isn't neutral on the question — it has simply never asked it. Hospitals are resource-intensive by nature: constant power draw, high water use, large volumes of single-use consumables, significant waste streams, substantial transport and supply chains. None of that is inherently wrong, but none of it gets smaller on its own either. Without a genuine strategic review, the hospital has no real starting point from which to improve, and every later sustainability effort — procurement, energy, carbon measurement — ends up disconnected from any actual understanding of where the hospital's impact is concentrated.

WHAT GOOD LOOKS LIKE

- Leadership has conducted a genuine, documented review of environmental impact.
- The review identifies specific negative impacts from the hospital's own activities.
- The review identifies realistic, actionable ways to mitigate those impacts.

COMMON FAILURE MODES

- No review has ever been conducted; environmental impact is simply not discussed at leadership level.
- A review exists but is generic, with no specific findings about this hospital's own activities.
- Findings exist but identify no realistic actions, leaving the review purely academic.

WORKED EXAMPLE

IN PRACTICE

A 180-bed hospital where sustainability had never been a board-level topic.

BEFORE	Environmental impact had never appeared on a board or senior management agenda. Energy, water and waste were managed operationally by facilities staff with no strategic oversight, and nobody could say with any confidence where the hospital's largest environmental impacts actually came from.
ACTION	The CEO commissioned a strategic review, led by the facilities director with input from clinical, procurement, and finance leads, covering energy use, water, waste streams, and supply chain. The review identified sterile processing energy use, single-use surgical drape volume, and food waste as the three largest concentrations of impact.
AFTER	The Monitor reviewed the completed strategic review document and interviewed the facilities director, who could describe the three priority areas and the reasoning behind them in specific, concrete terms. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Put environmental impact on a leadership agenda as a standing item, even briefly, to signal it is now a real topic.
2. Assign a named lead — facilities, quality, or sustainability — to coordinate an initial review.
3. Identify the two or three largest, most obvious sources of environmental impact as a starting point, not an exhaustive inventory.

The most common mistake: Treating environmental impact as a facilities-department operational matter rather than a genuine strategic question leadership has actually engaged with.

SELF-ASSESSMENT QUESTIONS

1. Has leadership conducted a genuine, documented review of the hospital's environmental impact, not left the question entirely

unaddressed? — A real strategic review, not an assumption that this falls outside the hospital's own responsibility.

Evidence: Strategic environmental review document

2. Does the review identify specific negative environmental impacts arising from the hospital's own activities? — *Genuine, specific findings, not a generic statement of good intent with no actual content.*

Evidence: Review findings, specific to this facility

3. Does the review identify realistic ways the hospital could mitigate those impacts, even partially? — *A real, actionable finding, not analysis that stops short of identifying what could actually change.*

Evidence: Documented mitigation recommendations

COMMON REASONS FOR A PARTIAL ANSWER

- **A review was conducted but findings are generic, not specific to this hospital's actual operations.** — A template review copied from elsewhere doesn't reflect this facility's real impact profile.
- **Findings are specific but no realistic mitigation actions were identified.** — Diagnosis without any proposed response leaves the review without practical value.
- **The review happened once, years ago, with no plan to revisit it.**

IMPLEMENTATION PLAN

When	What
Week 1	Place environmental impact on a leadership agenda and name a review lead.
Week 2-4	Conduct an initial review covering energy, water, waste, and supply chain.
Week 5	Identify and document the hospital's top three concentrations of impact.
Ongoing	Revisit the review on a defined schedule as operations and facilities change.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Strategic review document	Reviews the actual environmental impact review for specific, hospital-relevant findings.

Method	What	Detail
ASK	Leadership interview	Asks the review lead to describe the hospital's top environmental impact areas and why.

SUPERVISOR TIPS

- **Ask leadership directly what the hospital's biggest environmental impact actually is.** — A confident, specific answer reveals genuine engagement, not just a document on file.
- **Check whether the review's findings are specific to this hospital, not generic boilerplate.** — Specificity is the clearest sign a real review actually occurred.

EVIDENCE BASE

World Health Organization. Environmentally Sustainable Health Systems: A Strategic Document. Geneva: WHO; 2017.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

18.2

Staff and Patients Are Genuinely Informed of Sustainability Goals

STANDARD

The hospital's approach to environmentally sustainable care, and its goals in this area, are genuinely communicated to staff and patients — not confined to an internal policy document nobody outside senior management ever actually sees.

In plain terms: Staff and patients actually know the hospital has sustainability goals and roughly what they are — not because it's technically written down somewhere, but because someone actually told them.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

A sustainability strategy that lives only in a policy folder achieves very little. Staff are the people who actually decide, dozens of times a shift, whether to switch off equipment, use a reusable item instead of a disposable one, or report a wasteful practice — and they can only make those choices in line with hospital goals if they actually know what those goals are. Patients, too, increasingly care whether the facility treating them takes this seriously, and a hospital with genuine goals but no visible communication of them gets none of the credibility or staff engagement a real sustainability effort should earn.

WHAT GOOD LOOKS LIKE	COMMON FAILURE MODES
• Sustainability approach and goals are genuinely communicated to staff, not confined to policy. • The same information is genuinely available to interested patients. • Staff asked directly can describe at least one specific sustainability goal.	• A sustainability policy exists but has never been actively communicated to staff. • Information is available internally but never shared with patients in any form. • Staff asked directly have no idea the hospital has any sustainability goals at all.

WORKED EXAMPLE

IN PRACTICE	
<i>A hospital whose sustainability policy existed only as a PDF on the intranet.</i>	
BEFORE	A sustainability policy had been approved and filed on the intranet two years earlier. No staff briefing had ever been held. Interviewed staff, asked directly, had no idea such a policy existed or that the hospital had any specific environmental goals.

ACTION

A one-page summary of the three priority goals

was created, presented at department meetings, posted in staff break rooms, and added to new-staff orientation. A short, plain-language version was added to the patient information booklet and hospital website.

AFTER

The Monitor asked five staff members at random about sustainability goals; four could name at least one specific goal accurately. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Reduce the sustainability approach to a short, one-page, plain-language summary.
2. Present it at a real staff meeting, not only post it somewhere.
3. Add a short patient-facing version to existing patient information materials.

The most common mistake: Treating policy approval as equivalent to communication, when staff have never actually been told the policy exists.

SELF-ASSESSMENT QUESTIONS

1. Is the hospital's sustainability approach and its goals genuinely communicated to staff, not confined to a policy document? — *Real, visible communication, not information technically available but never actually shared.*

Evidence: Staff briefing materials, meeting agendas

2. Is the same information genuinely available to patients who want it, not withheld as an internal-only matter? — *Genuine patient-facing transparency, not sustainability treated as purely an internal concern.*

Evidence: Patient-facing information materials

3. Can staff asked directly describe at least one specific sustainability goal the hospital is working toward? — *Tests whether communication actually reached staff, not just whether it was technically issued.*

Evidence: Staff interview

- **Staff communication happened once, at policy launch, with no reinforcement since.** — A single mention long ago is easily forgotten by the time it matters.
- **Information reaches clinical staff but not support or contracted staff.** — Genuine communication should reach everyone whose daily choices affect sustainability.
- **Patient-facing information exists but is hard to find or rarely noticed.**

IMPLEMENTATION PLAN

When	What
Week 1	Create a short, plain-language summary of sustainability goals.
Week 2	Present it at real department meetings across clinical and support staff.
Week 3	Add a patient-facing version to existing information materials.
Ongoing	Reinforce periodically, including in new-staff orientation.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks staff at random whether they can describe a specific sustainability goal.
DOCUMENT	Patient materials review	Reviews patient-facing materials for genuine inclusion of sustainability information.

SUPERVISOR TIPS

- **Ask a support-services or contracted staff member, not only clinical staff, about sustainability goals.** — Genuine communication reaches everyone, not only the department that wrote the policy.
- **Ask a patient in the waiting area if they've seen anything about the hospital's sustainability efforts.** — A real, visible presence is the clearest test of genuine patient-facing communication.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

18.3

Sustainability Progress Is Actually Reported to Governance

STANDARD

Progress against the hospital’s environmental sustainability goals is genuinely reported to governance on a defined schedule — not tracked informally by whoever happens to care about it, with no real visibility at the level that sets institutional priorities.

In plain terms: The board or governing body actually sees real data on sustainability progress on a regular schedule — not a topic that exists only at the enthusiasm of one individual with no real institutional visibility.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Sustainability initiatives that depend entirely on one enthusiastic individual tend to disappear the moment that person moves on, exactly like any other initiative without real institutional backing. Reporting progress to governance is what converts a personal project into an organisational commitment — it means resourcing decisions, capital investments, and strategic priorities can actually take sustainability progress into account, and it means the effort survives staff turnover because it is now a standing item the institution itself tracks, not a passion project tied to one person’s tenure.

WHAT GOOD LOOKS LIKE

- Progress is genuinely reported to governance on a real, defined schedule.

COMMON FAILURE MODES

- Sustainability tracking exists informally with no

- Governance actually reviews this progress, not just receives it passively.
- A documented instance exists of a governance decision informed by this data.

real reporting line to governance.

- Reports are submitted but never discussed or genuinely reviewed.
- No decision has ever visibly been influenced by sustainability progress data.

WORKED EXAMPLE

IN PRACTICE

A hospital where sustainability tracking was an informal side project of the facilities manager.

BEFORE	The facilities manager tracked energy and waste data in a personal spreadsheet, shared informally with colleagues but never presented to the board. When she went on extended leave, tracking stopped entirely for four months.
ACTION	Sustainability progress was added as a standing quarterly board agenda item, with a one-page dashboard prepared each quarter covering energy, waste, and procurement metrics against the hospital's stated goals.
AFTER	The Monitor reviewed board minutes showing four consecutive quarters of genuine sustainability review, including one instance where a capital budget request for LED lighting was approved with explicit reference to the sustainability dashboard. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add sustainability progress as a standing governance agenda item, even quarterly.
2. Build a simple one-page dashboard covering the goals identified in the strategic review.
3. Ensure whoever currently tracks the data isn't the only person who could present it.

The most common mistake: Letting sustainability tracking

remain the informal, personal effort of one enthusiastic staff member, with no real institutional reporting line.

SELF-ASSESSMENT QUESTIONS

1. Is progress against sustainability goals genuinely reported to governance on a real, defined schedule? — *A real reporting cadence, not tracking that exists informally with no genuine visibility upward.*

Evidence: Governance meeting agendas, sustainability reports

2. Does governance actually review this progress, not simply receive it as an unexamined item? — *Genuine review, not a report circulated and filed without real engagement.*

Evidence: Governance meeting minutes

3. Is there a documented instance of a governance-level decision informed by sustainability progress data? — *A real, concrete example, not a theoretical reporting line with no actual influence on decisions.*

Evidence: Specific decision record referencing sustainability data

COMMON REASONS FOR A PARTIAL ANSWER

- **Reports reach governance but minutes show no real discussion occurred.** — Passive receipt isn't the same as the genuine review the criterion requires.
- **Reporting happened for a time but lapsed when the responsible person changed.** — Genuine institutional reporting should survive individual staff turnover.
- **No concrete example exists of a decision actually shaped by the data.**

IMPLEMENTATION PLAN

When	What
Week 1	Add sustainability progress as a standing governance agenda item.
Week 2-3	Build a simple, repeatable progress dashboard tied to stated goals.
Ongoing	Present and genuinely discuss progress at each scheduled interval.

Method	What	Detail
DOCUMENT	Governance minutes review	Reviews minutes for genuine, recurring sustainability progress discussion.
DOCUMENT	Decision record review	Looks for a specific decision genuinely informed by sustainability data.

SUPERVISOR TIPS

- **Ask a governing body member to describe the hospital's current sustainability progress.** — A confident, specific answer reveals genuine engagement, not a report skimmed and filed.
- **Check whether reporting continued through any recent staff transition.** — Genuine institutional reporting survives individual turnover; informal tracking doesn't.

EVIDENCE BASE

Institute for Healthcare Improvement. Leading Quality Improvement: Essential Skills for Healthcare Managers. Boston: IHI; 2016.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

18.4 Procurement Genuinely Considers Responsible Stewardship of Resources

CORE

The hospital's procurement and supply decisions genuinely take environmental and social responsibility into account — reducing wasteful use of supplies, considering supplier environmental practices, and reviewing single-use equipment decisions against genuine patient and staff safety requirements — not sustainability treated as irrelevant to purchasing choices actually made.

In plain terms: When the hospital buys things, it actually thinks about waste and supplier responsibility, not just unit price — while never once compromising patient or staff safety to do so.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Procurement is where a hospital’s environmental impact actually gets decided, purchase order by purchase order — far more than any policy statement. A hospital buying disposable items it could safely use reusable alternatives for, sourcing from suppliers with no environmental accountability, or over-ordering with no real check on waste, is making a genuine environmental choice every time, whether or not anyone thinks of it that way. This is marked Core because it is the single point in hospital operations where sustainability intentions either translate into real purchasing behaviour or remain purely theoretical — and because the safety dimension is just as critical: an environmental choice that compromises infection control or patient safety fails this criterion regardless of its environmental merit.

WHAT GOOD LOOKS LIKE

- Supplier environmental and social responsibility practices genuinely inform procurement decisions.
- Wasteful use of supplies is genuinely reviewed and reduced where safely possible.
- Patient and staff safety is explicitly, verifiably protected in any single-use equipment reconsideration.

COMMON FAILURE MODES

- Procurement decisions are made on price and availability alone, with no sustainability consideration.
- Waste reduction is discussed but no real purchasing pattern has actually changed.
- Single-use equipment is reconsidered without genuine, verified safety review.

WORKED EXAMPLE

IN PRACTICE

A hospital whose procurement decisions were made entirely on unit cost.

BEFORE

Procurement selected suppliers purely on lowest unit price, with no questions asked about environmental practices. Significant packaging

waste accumulated from over-individually wrapped items with no review of bulk alternatives.

ACTION	A sustainability criterion was added to the supplier evaluation checklist alongside price and quality. Packaging waste was reviewed with the infection control team, and several items were switched to bulk packaging where this didn't compromise sterility requirements, with the infection control lead signing off on each change.
AFTER	The Monitor reviewed the updated supplier evaluation checklist, confirmed infection control sign-off existed for each packaging change, and interviewed the procurement lead who could describe the specific reasoning behind recent purchasing decisions. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add an environmental/social responsibility question to the supplier evaluation process.
2. Identify the highest-volume sources of avoidable waste in current purchasing.
3. Involve infection control explicitly before changing any single-use equipment decision.

The most common mistake: Changing a single-use equipment decision for environmental reasons without genuine, documented infection-control sign-off first.

SELF-ASSESSMENT QUESTIONS

1. Do procurement decisions genuinely take supplier environmental and social responsibility practices into account? — *A real, documented consideration, not a purchasing process blind to anything beyond unit price.*
Evidence: Supplier evaluation criteria
2. Is wasteful use of supplies — packaging, single-use items, unnecessary ordering — genuinely reviewed and reduced where safely possible? — *Real reduction efforts, not an assumption that*

3. Where single-use equipment is reconsidered, is patient and staff safety — infection control, manufacturer guidance — genuinely protected throughout? — *Safety never compromised for an environmental goal, verified, not assumed.*

Evidence: Infection control sign-off records

COMMON REASONS FOR A PARTIAL ANSWER

- **Sustainability is considered for new suppliers but existing supplier relationships are never reviewed.** — A criterion applied only going forward leaves the bulk of existing procurement unexamined.
- **Waste reduction ideas are discussed but no actual purchasing change has occurred.** — Discussion without a real, implemented change doesn't meet this criterion.
- **A single-use item was changed without formal infection control review beforehand.**

IMPLEMENTATION PLAN

When	What
Week 1	Add sustainability criteria to the supplier evaluation process.
Week 2-3	Identify the largest sources of avoidable procurement waste.
Week 4	Review candidate changes with infection control before any implementation.
Ongoing	Periodically reassess existing supplier relationships, not only new ones.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Supplier evaluation review	Reviews procurement criteria for genuine inclusion of sustainability factors.
DOCUMENT	Infection control sign-off review	Confirms safety review genuinely occurred before any single-use equipment change.

- **Ask procurement staff to describe a recent purchasing decision shaped by sustainability considerations.** — A real, specific example confirms genuine practice, not a policy that exists only on paper.
- **Check that infection control, not procurement alone, signed off on any single-use change.** — Safety sign-off from the right discipline is non-negotiable regardless of environmental merit.

EVIDENCE BASE

World Health Organization. Compendium of WHO and Other UN Guidance on Health and Environment. Geneva: WHO; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

18.5

Energy Use Is Monitored, With a Genuine Move Toward Renewable Sources

STANDARD

The hospital genuinely monitors its use of electricity, gas, and other fuel sources, and takes real steps toward reducing reliance on fossil fuels where this is practically possible — not energy use left entirely unmeasured and unmanaged as a fixed, unexamined operating cost.

In plain terms: The hospital actually tracks how much energy it uses and from what source, and has genuinely tried at least one real step toward using less fossil fuel — not treating the power bill as a cost nobody ever actually examines.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Energy use is one of the most measurable, most immediately actionable parts of a hospital's environmental impact — and one of the easiest to simply never look at closely, since the bill arrives and gets

paid regardless of whether anyone understands what's driving it. A hospital that genuinely monitors its energy use, broken down by source and area, can identify real opportunities most facilities never discover simply because nobody looked: outdated lighting, equipment left running unnecessarily, inefficient heating and cooling scheduling. None of this requires large capital investment to start — it requires someone actually paying attention.

WHAT GOOD LOOKS LIKE

- Electricity, gas, and fuel use are genuinely, ongoingly monitored.
- At least one genuine, concrete step toward reduced fossil fuel reliance has been taken.
- Renewable energy feasibility has been genuinely assessed where options exist locally.

COMMON FAILURE MODES

- Energy bills are paid but usage is never actually tracked or analysed.
- Energy reduction is discussed as an aspiration with no concrete action taken.
- Renewable energy is assumed impractical without any real feasibility assessment.

WORKED EXAMPLE

IN PRACTICE	
A hospital that had never broken down its energy use by source or area.	
BEFORE	Monthly utility bills were paid without review. Nobody could say what proportion of energy use came from lighting, HVAC, or medical equipment, or whether usage was trending up or down over time.
ACTION	The facilities team began tracking monthly electricity and gas use against a baseline, broken down where meters allowed. Older fluorescent lighting in non-clinical corridors was replaced with LED fixtures, and a local solar feasibility assessment was commissioned for the facility's roof space.
AFTER	The Monitor reviewed six months of tracked energy data showing a real, measured reduction

following the lighting change, and the solar feasibility report, even though installation hadn't yet been decided. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Start logging monthly energy use from existing utility bills, even without granular metering.
2. Identify one low-cost, low-risk efficiency change — lighting is often the easiest starting point.
3. Ask a local renewable energy provider for a basic feasibility assessment, even if implementation isn't imminent.

The most common mistake: Assuming renewable energy or efficiency improvements are automatically impractical without ever actually commissioning a real assessment.

SELF-ASSESSMENT QUESTIONS

1. Is the hospital's use of electricity, gas, and other fuel sources genuinely monitored, not left entirely untracked? — *Real, ongoing monitoring, not energy treated as an unexamined fixed cost.*

Evidence: Energy use tracking records

2. Has the hospital taken any genuine, concrete step toward reducing fossil fuel reliance where practically possible? — *A real, specific action, not a stated aspiration with no actual change behind it.*

Evidence: Documented energy efficiency or reduction initiative

3. Where renewable energy options exist locally, has the hospital genuinely assessed their feasibility? — *A real assessment, not an assumption that renewable transition is automatically impractical.*

Evidence: Renewable energy feasibility assessment

COMMON REASONS FOR A PARTIAL ANSWER

- **Energy use is monitored but no action has followed from what the data shows.** — Measurement alone, with no resulting change, only partially meets the intent.
- **A reduction step was taken once but monitoring hasn't continued since.** — Genuine, ongoing monitoring is what this criterion actually requires.
- **Renewable feasibility was assumed negative without ever being formally assessed.**

When	What
Week 1	Begin logging monthly energy use from existing utility data.
Week 2-4	Identify and implement at least one low-cost efficiency improvement.
Month 2	Commission a basic renewable energy feasibility assessment.
Ongoing	Continue tracking usage and reviewing trends over time.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Energy tracking review	Reviews actual logged energy use data over a meaningful period.
DOCUMENT	Feasibility assessment review	Reviews any renewable energy feasibility assessment commissioned.

SUPERVISOR TIPS

- **Ask facilities staff to show real energy use data, not just describe intentions.** — Actual tracked data is the clearest evidence genuine monitoring is occurring.
- **Ask whether a renewable energy assessment has ever actually been commissioned.** — Distinguishes a genuine assessment from an assumption that renewables aren't viable.

EVIDENCE BASE

International Energy Agency. Healthy Energy, Healthy People: Energy Efficiency in Healthcare. Paris: IEA; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

18.6

A Genuine Carbon Footprint Baseline Exists

STANDARD

The hospital has carried out a genuine assessment of its carbon footprint — even based on a minimal dataset such as energy use alone — to establish a real baseline for monitoring and reducing greenhouse gas emissions, not treating carbon impact as something too complex to ever actually measure.

In plain terms: The hospital has actually calculated, even roughly, how much greenhouse gas its operations produce — a real starting number, not an assumption that this is too technical to ever attempt.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A carbon footprint baseline doesn’t need to be sophisticated to be genuinely useful — a reasonable estimate based on energy use alone is a real, legitimate starting point, and far more valuable than no baseline at all. Without even a minimal baseline, a hospital has no way to know whether any sustainability effort it undertakes is actually reducing emissions or not — every subsequent initiative operates blind. ISQua EEA explicitly recognises that organisations will have different scope and resources for this, and a minimal, honest baseline fully meets the intent here; waiting for a perfect, comprehensive carbon accounting system before starting is itself the failure mode.

WHAT GOOD LOOKS LIKE

- A genuine carbon footprint assessment exists, even a minimal one based on energy use.
- The baseline is genuinely used to monitor change over time.
- A realistic plan exists to extend the assessment as

COMMON FAILURE MODES

- No carbon footprint assessment has ever been attempted, on the assumption it’s too complex.
- A baseline was calculated once and never used again to track anything.

WORKED EXAMPLE

IN PRACTICE	
A hospital that had assumed carbon footprint measurement was beyond its resources.	
BEFORE	Carbon footprint had never been discussed, on the assumption that proper measurement required expertise and resources the hospital didn't have.
ACTION	Using a free, publicly available carbon calculator and the hospital's existing energy use data, the facilities team produced a minimal baseline covering electricity and gas consumption, clearly documenting what was and wasn't included in the estimate.
AFTER	The Monitor reviewed the baseline document, confirmed it was being used as a comparison point in the following year's energy report, and found a documented plan to extend the baseline to include waste and transport once resources allowed. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Use a free, publicly available carbon calculator with existing energy billing data.
2. Document clearly what the baseline does and doesn't cover.
3. Commit, even informally, to revisiting the baseline annually.

The most common mistake: Waiting for a comprehensive, professionally commissioned carbon accounting system before attempting any baseline at all.

1. Has the hospital carried out a genuine carbon footprint assessment, even a minimal one based on energy use? — *A real, documented baseline, not an assumption that measurement is too complex to attempt.*

Evidence: Carbon footprint baseline document

2. Is this baseline genuinely used to monitor change over time, not calculated once and never revisited? — *Real, ongoing tracking, not a one-time exercise with no follow-through.*

Evidence: Year-over-year comparison data

3. Is there a realistic plan to extend the carbon footprint assessment as hospital resources allow? — *A genuine forward plan, not a minimal baseline treated as a permanent ceiling on ambition.*

Evidence: Documented extension plan

COMMON REASONS FOR A PARTIAL ANSWER

- **A baseline was calculated but is never actually referenced again afterward.** — A baseline that is never revisited doesn't function as a genuine monitoring tool.
- **The baseline is accurate but its scope and limitations aren't clearly documented.** — Unclear scope makes future comparison unreliable.
- **No plan exists to extend the baseline beyond its current minimal scope.**

IMPLEMENTATION PLAN

When	What
Week 1	Gather existing energy billing data for the past 12 months.
Week 2	Use a recognised carbon calculator to produce an initial baseline.
Week 3	Document the baseline's scope and limitations clearly.
Ongoing	Revisit annually and extend scope as resources allow.

Method	What	Detail
DOCUMENT	Baseline document review	Reviews the actual carbon footprint baseline and its documented scope.
DOCUMENT	Trend comparison review	Confirms the baseline is genuinely used for year-over-year comparison.

SUPERVISOR TIPS

- **Ask to see the baseline document and whether it's been updated or referenced since creation.** — A baseline that exists but is never used again doesn't meet the genuine intent here.
- **Accept a minimal, honestly-scoped baseline as fully meeting this criterion.** — ISQua explicitly recognises resource constraints; don't expect more than is realistic.

EVIDENCE BASE

NHS Sustainable Development Unit. Carbon Footprint Update for NHS in England. Cambridge: SDU; 2022.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

18.7

The Hospital Genuinely Plans for Environmental and Climate Resilience

CORE

The hospital considers its resilience to major environmental, climate, or health emergencies that could disrupt service delivery — heatwaves, flooding, extreme storms, pandemic outbreaks — and plans a real range of actions in response, not assuming such disruptions are too remote to actually prepare for.

In plain terms: The hospital has a real plan for what happens if extreme weather, flooding, or another major environmental disruption hits — not an assumption that this won't happen here, or that existing emergency plans already cover it without anyone actually checking.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Climate and environmental disruptions are not a distant, theoretical risk — heatwaves straining cooling systems and patients alike, flooding disabling ground-floor departments, extreme storms cutting power and supply chains, are events hospitals around the world are facing with increasing frequency. This is marked Core because the consequence of inadequate preparation isn’t abstract: a hospital caught unprepared by a major environmental emergency risks exactly the kind of care disruption and patient safety failure the whole rest of this standards document exists to prevent. A generic, unreviewed emergency plan that has never actually considered climate-specific scenarios doesn’t meet this intent — the hospital needs to have genuinely thought through its own specific vulnerabilities.

WHAT GOOD LOOKS LIKE

- The hospital has genuinely considered its resilience to climate/environmental emergencies relevant to its location.
- A real plan exists for situational response that protects patient safety and care continuity.
- The plan is genuinely reviewed and updated, not static and unexamined.

COMMON FAILURE MODES

- No specific consideration has been given to environmental or climate emergencies at all.
- A generic emergency plan exists but was never adapted for climate-specific scenarios.
- A plan exists but hasn’t been reviewed or updated in years, regardless of changing conditions.

WORKED EXAMPLE

IN PRACTICE

A hospital whose emergency plan covered fire and security but not climate-specific risks.

BEFORE

The hospital’s emergency response plan covered fire, security incidents, and mass casualty events, but had never specifically addressed heatwave response, flooding of ground-floor areas, or

extended power loss during extreme weather despite the region's increasing frequency of severe storms.

ACTION

A climate risk assessment specific to the hospital's location and structure was conducted, identifying flooding of the ground-floor emergency department and summer cooling capacity as the two highest-priority risks. Specific response protocols were added: a flood barrier and relocation plan for the emergency department, and a heat-response protocol with backup cooling arrangements.

AFTER

The Monitor reviewed the updated emergency plan, confirmed it addressed location-specific climate risks with real response protocols, and found evidence of an annual review cycle already underway. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Identify the one or two climate/environmental risks most relevant to the hospital's actual location.
2. Check whether the existing emergency plan genuinely addresses these, or only generic incidents.
3. Add specific, actionable response protocols for the highest-priority identified risks.

The most common mistake: Assuming a general emergency response plan already covers climate-specific scenarios without anyone actually checking whether it does.

SELF-ASSESSMENT QUESTIONS

1. Has the hospital genuinely considered its resilience to major environmental or climate emergencies relevant to its location? — *A real, specific assessment, not an assumption that such events are too remote to plan for.*

Evidence: Location-specific climate risk assessment

2. Does a real plan exist for situational assessment and response that protects patient safety and continuity of care during such an

emergency? — *A genuine, actionable plan, not a general statement of intent with no real content.*

Evidence: Climate/environmental emergency response protocol

3. Is the plan genuinely reviewed and updated, not written once and left unexamined as conditions change? — *Real, periodic review, not a static document assumed to remain adequate indefinitely.*

Evidence: Plan review schedule and revision history

COMMON REASONS FOR A PARTIAL ANSWER

- **A general emergency plan exists but has never been specifically checked against climate risks.** — Generic coverage doesn't confirm the hospital's specific vulnerabilities are actually addressed.
- **Climate risks are identified but response protocols remain vague or untested.** — Identification without a genuine, actionable response plan leaves the gap unresolved.
- **The plan was written once with no subsequent review as conditions or evidence changed.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Conduct a location-specific climate and environmental risk assessment.
Week 3-4	Develop specific response protocols for the highest-priority identified risks.
Week 5	Integrate these into the hospital's existing emergency response plan.
Ongoing	Review and update the plan on a defined annual schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Climate risk assessment review	Reviews the specific, location-relevant environmental risk assessment.
DOCUMENT	Response plan review	Reviews the emergency plan for genuine, specific climate-related protocols.

Method	What	Detail
ASK	Staff interview	Asks relevant staff to describe the hospital's response to an identified climate risk.

SUPERVISOR TIPS

- **Ask whether the emergency plan names the hospital's specific climate risks, not just generic incidents.** — Specificity to this facility's actual location and structure is the real test here.
- **Check the plan's last review date against how long ago it was first written.** — A plan untouched for years, regardless of changing conditions, has likely gone stale.

EVIDENCE BASE

World Health Organization. Operational Framework for Building Climate Resilient and Low Carbon Health Systems. Geneva: WHO; 2023.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

- ← **Hospital Standards — all standards**
- Self-assess against these criteria →**
- ← **Standard 17 — Enterprise & Multi-Site Governance**
- Standard 19 — Digital Care & AI →**

ASF STANDARDS · HOSPITAL · STANDARD 19

Standard 19 — Digital Care and Artificial Intelligence Systems for Care

7 criteria · 1 core · 6 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 7, 6th Edition

CRITERIA IN THIS STANDARD

19.1 — Digital Care Systems Follow a Genuine Assessment and Management Process

19.2 — Digital Care Never Disadvantages a Patient Who Cannot Use It

19.3 — Genuine Technical Expertise Supports Digital Care Systems

19.4 — AI Systems Are Introduced in Line With Law and Best-Practice Guidance

19.5 — AI Systems Are Genuinely Monitored for Unintended Consequences

19.6 — Staff Are Genuinely Consulted Before an AI System Is Introduced

19.7 — Accountability for AI-Assisted Care Is Explicitly Defined

19.8 — Patients Are Genuinely Informed When Their Care Involves AI

19.1

Digital Care Systems Follow a Genuine Assessment and Management Process

STANDARD

Before any digital care system — telehealth platform, remote monitoring tool, patient-facing app — is introduced, the hospital genuinely assesses its costs and benefits, manages its implementation, and continues to manage it afterward — not adopted because a vendor made a compelling pitch, with no real internal evaluation.

In plain terms: Before the hospital adopts a new digital tool, someone has actually weighed up whether it’s worth it, checked it will work with what the hospital already has, and thought through what could go wrong — not bought it because the demo looked impressive.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Digital care systems are often introduced through enthusiasm, vendor pressure, or a genuine desire to modernise — all understandable, none of them a substitute for real evaluation. A hospital that adopts a new telehealth platform or remote monitoring tool without checking whether it actually integrates with existing systems, without weighing its real costs against its real benefits, and without considering what could go wrong, risks ending up with a system that creates more problems than it solves: data trapped in a system that doesn’t talk to the patient record, clinical staff working around a tool rather than with it, or patient safety risks nobody anticipated because nobody looked.

WHAT GOOD LOOKS LIKE

- A genuine cost/benefit analysis happens before implementation, not after.
- Interoperability with existing systems is genuinely assessed and risks mitigated.

COMMON FAILURE MODES

- A system is adopted based on a vendor demonstration with no independent evaluation.
- Interoperability problems only surface after the system is already in clinical use.

• Potential unintended consequences are considered proactively, not discovered in hindsight.

• Unintended consequences are never considered until they actually occur.

WORKED EXAMPLE

IN PRACTICE	
A hospital considering a new remote patient monitoring platform.	
BEFORE	A vendor presented a remote monitoring platform at a conference. The CMO was impressed and initiated procurement directly, with no formal evaluation of cost, benefit, or compatibility with the hospital's existing electronic health record.
ACTION	A structured evaluation was introduced: IT assessed interoperability with the existing EHR, finance modelled real cost against projected benefit in reduced readmissions, and clinical staff were asked to identify likely unintended consequences, such as alert fatigue from excessive monitoring notifications.
AFTER	The Monitor reviewed the completed evaluation document, including the interoperability assessment and the identified alert-fatigue risk with its mitigation plan. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a simple evaluation template covering cost, benefit, interoperability, and risk.
2. Require this template be completed before any digital system procurement proceeds.
3. Involve both IT and the clinical staff who will actually use the system in the evaluation.

The most common mistake: Letting enthusiasm for a new technology substitute for a genuine, structured evaluation of its costs, interoperability, and risks.

1. Is a genuine cost/benefit analysis conducted before any digital care system is implemented, not adopted on vendor assurance alone? — *A real, documented evaluation, not a decision made purely on a sales pitch.*

Evidence: Digital system evaluation documentation

2. Is interoperability between the new system and existing hospital systems genuinely assessed, with risks from non-interoperability actually mitigated? — *Real risk assessment, not an assumption that systems will simply work together.*

Evidence: Interoperability assessment

3. Are potential unintended consequences of introducing the system genuinely considered before implementation, not discovered only afterward? — *Real, proactive consideration, not a system deployed and its effects observed only in hindsight.*

Evidence: Pre-implementation risk review

COMMON REASONS FOR A PARTIAL ANSWER

- **A cost/benefit analysis exists but interoperability was never formally checked.** — Financial evaluation alone doesn't confirm the system will actually integrate safely.
- **Evaluation happens for major systems but is skipped for smaller, seemingly low-risk tools.** — A consistent process should apply regardless of how minor a new system initially seems.
- **Unintended consequences are discussed informally but never actually documented.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a structured evaluation template for digital system procurement.
Week 2	Require the template's completion as a formal procurement gate.
Ongoing	Apply the process consistently to every new digital care system, regardless of scale.

Method	What	Detail
DOCUMENT	Evaluation document review	Reviews a recent digital system evaluation for genuine cost/benefit and interoperability analysis.
ASK	IT/clinical interview	Asks whether unintended consequences were genuinely considered before a recent system's launch.

SUPERVISOR TIPS

- **Ask to see the evaluation for the most recently introduced digital care system.** — A real, recent example is the clearest evidence this process genuinely functions.
- **Ask IT staff directly whether interoperability was checked before go-live, not after.** — Timing matters — a check performed after deployment doesn't meet the intent.

EVIDENCE BASE

World Health Organization. Global Strategy on Digital Health 2020-2025. Geneva: WHO; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

19.2

Digital Care Never Disadvantages a Patient Who Cannot Use It

CORE

A genuine process ensures that patients who cannot use digital devices, lack internet access, or are otherwise unable to engage with digital approaches are never disadvantaged by the hospital's use of digital care — not digital convenience for most patients purchased at the cost of real access for the patients least able to adapt.

In plain terms: A patient who can't use a smartphone or doesn't have internet access still gets exactly the same quality of care as everyone else — a real, working

alternative, not a second-class pathway nobody actually tested.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Digital care genuinely improves access and convenience for many patients — but the patients least likely to benefit are often exactly the patients most vulnerable to begin with: older people, those with lower digital literacy, those in poverty without reliable internet access, people with disabilities that make digital interfaces harder to use. This is marked Core because the risk here isn’t inconvenience — it’s a genuine equity failure where a hospital’s digital modernisation effort quietly degrades care for precisely the patients who can least absorb that degradation. A real, tested, equally functional alternative isn’t optional; it’s what makes digital care an addition to patient access rather than a subtraction from it.

WHAT GOOD LOOKS LIKE

- A genuine, defined alternative exists for patients who cannot use a digital approach.
- New digital services are genuinely pre-tested with representatives of affected patient groups.
- Real evidence shows patients using the alternative received equivalent, undiminished service.

COMMON FAILURE MODES

- A digital-only pathway exists with no real, functioning alternative for patients who can’t use it.
- A new digital service launches without ever being tested with patients who might struggle.
- An alternative exists on paper but patients using it experience a genuinely worse service.

WORKED EXAMPLE

IN PRACTICE

A hospital that moved appointment booking to an app-only system.

BEFORE

Outpatient appointment booking moved to a smartphone app, with the old phone-booking line quietly deprioritised and often leaving callers on

hold for 20 minutes or more. Older patients and those without smartphones found booking appointments had become significantly harder.

ACTION

The phone-booking line was restored to equal staffing priority alongside the app, with wait times actively monitored to confirm genuine parity. The app rollout for future digital services was changed to include pre-testing with a panel of older patients before launch.

AFTER

The Monitor called the phone-booking line directly and reached a human within two minutes, matching the app's typical booking time, and reviewed pre-testing documentation for the hospital's most recent digital service launch. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Identify every current digital-only patient-facing process and check for a real alternative.
2. Test the alternative yourself — call it, try it — to confirm it's genuinely equivalent, not degraded.
3. Build pre-testing with affected patient groups into how future digital services are launched.

The most common mistake: Assuming an old, non-digital process still functions as a real alternative without ever actually testing whether it's been quietly left to degrade.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, defined alternative for patients who cannot or do not want to use a digital care approach? — *A real, equally functional alternative, not a digital-only pathway with no real fallback.*
Evidence: Documented alternative access pathway

2. Was the introduction of a new digital care service genuinely pre-tested with representatives of patients who might struggle to use it? — *Real, prior testing with the affected group, not an assumption that accessibility will work out.*
Evidence: Pre-launch testing documentation

3. Is there evidence that a patient unable to use digital care actually received equivalent, undiminished service through the alternative route? — *A real, demonstrated instance, not a theoretical alternative that has never actually been tested in practice.*

Evidence: Service comparison data or direct test

COMMON REASONS FOR A PARTIAL ANSWER

- **An alternative exists but is genuinely slower or lower-quality than the digital route.** — Nominal equivalence isn't the same as a service that's actually equally good.
- **Pre-testing happened for one digital service but isn't a consistent practice.** — Genuine protection against disadvantage should apply to every new digital service, not just one.
- **The alternative is known to staff but not actively communicated to patients who need it.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit every current digital-only patient process for a genuine alternative.
Week 2	Test each alternative directly to confirm real equivalence, not just nominal existence.
Ongoing	Require pre-testing with affected patient groups for every new digital service.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Direct alternative test	Personally tests the non-digital alternative pathway for a genuine, equivalent experience.
DOCUMENT	Pre-testing review	Reviews pre-launch testing records for recent digital service introductions.

SUPERVISOR TIPS

- **Personally try the non-digital alternative, not just confirm it exists on paper.** — Direct testing reveals whether an alternative is genuinely equivalent or quietly degraded.
- **Ask frontline staff whether patients ever complain about struggling with a digital-only process.** — Real staff experience often surfaces equity gaps before they appear in any formal record.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

19.3

Genuine Technical Expertise Supports Digital Care Systems

STANDARD

The hospital has genuine access to technical expertise — in-house, vendor-provided, or contracted — to support the effective use of its digital care systems, including testing and quality checks before full implementation, not digital systems left running with no real technical support behind them.

In plain terms: When a digital system breaks or a clinician needs help using it properly, there’s a real person to call — not a system left to run itself with nobody actually responsible for keeping it working.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A digital care system is only as reliable as the support behind it. Software updates, integration issues, unexpected errors, and the ordinary friction of real-world clinical use all require genuine technical capacity to resolve — and a hospital that adopts digital systems without securing that capacity first is setting staff up to work around problems rather than have them properly fixed. This isn’t about having a large in-house IT department; a small hospital can meet this through a solid vendor support contract or a shared regional technical resource, as long as that support is genuinely accessible when actually needed.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Genuine, accessible technical expertise exists for every digital care system in use.
- Testing and quality checks genuinely occur before full implementation, not after.
- A real, known escalation path exists when a digital system issue arises.

- A digital system is in use with no clear technical support arrangement at all.
- Testing happens informally, if at all, with issues discovered only after patients are affected.
- Staff don't know who to contact when a digital system malfunctions.

WORKED EXAMPLE

IN PRACTICE	
A small hospital running a telehealth platform with no formal support arrangement.	
BEFORE	The telehealth platform had been set up by a staff member who has since left. When it malfunctioned, nobody currently on staff knew who to contact, and clinical sessions were cancelled for two days while someone tracked down the original vendor contact.
ACTION	A formal support contract was signed with the platform vendor, including a defined response-time guarantee. A named internal staff member was designated as the primary point of contact, with vendor support details posted visibly for all clinical staff using the system.
AFTER	The Monitor confirmed the support contract existed with a genuine response-time commitment, and interviewed a clinical staff member who could correctly describe who to contact for a technical issue. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every digital care system currently in use and confirm whether each has a real support arrangement.
2. For any gap, secure a vendor support contract or designate an internal technical lead.

The most common mistake: Technical support knowledge living entirely with one staff member, with no documented arrangement that survives their departure.

SELF-ASSESSMENT QUESTIONS

1. Does the hospital have genuine, accessible technical expertise — in-house or contracted — for its digital care systems? — *Real, available support, not systems left to run unsupported once installed.*

Evidence: Technical support contract or arrangement

2. Were new testing and quality checks genuinely performed before full implementation of a digital care system? — *A real pre-launch verification process, not a system deployed directly to patients untested.*

Evidence: Pre-implementation testing records

3. When a digital system issue arises, is there a real, known route to technical support, not staff left to troubleshoot alone? — *A genuine, known escalation path, not an assumption that someone will eventually sort it out.*

Evidence: Staff interview, posted support contact

COMMON REASONS FOR A PARTIAL ANSWER

- **Support exists for major systems but not for smaller, department-level digital tools.** — Genuine coverage should extend to every digital care system in clinical use.
- **A support contract exists but staff don't actually know it exists or how to use it.** — Support that nobody knows how to access doesn't function in practice.
- **Testing occurred before initial launch but not for subsequent updates or changes.**

IMPLEMENTATION PLAN

When	What
Week 1	Inventory all digital care systems and their current support status.
Week 2-3	Secure or formalize support arrangements for any system lacking one.

When	What
Week 4	Communicate support contacts clearly to all relevant staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Support arrangement review	Reviews the technical support contract or arrangement for each digital system.
ASK	Staff interview	Asks a staff member who they would contact for a digital system issue.

SUPERVISOR TIPS

- **Ask a frontline clinical user, not IT staff, who they’d call if the system failed mid-shift.** — The end user’s actual knowledge is the real test of whether support is genuinely accessible.
- **Check whether support knowledge depends entirely on one individual staff member.** — A single point of failure in support knowledge is a real, specific risk worth probing.

EVIDENCE BASE

NHS Digital. Technology Assessment Criteria for Digital Health Products. London: NHS Digital; 2022.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

19.4

AI Systems Are Introduced in Line With Law and Best-Practice Guidance

STANDARD

Any artificial intelligence system used to support diagnosis, triage, or care decisions is introduced and managed in accordance with applicable national or regional law and regulation, or in their absence, available best-practice guidance such as WHO’s ethics and governance guidance for AI — not adopted with no reference to any external standard of responsible use.

In plain terms: Before using an AI tool in patient care, the hospital has actually checked what the law requires, or if there's no specific law, has grounded its approach in real published guidance — not made it up as it went along.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

AI regulation in healthcare is evolving rapidly and unevenly across jurisdictions — some regions have specific, binding requirements; many do not yet. In the absence of binding law, a hospital is not free to simply do whatever it wants with clinical AI; credible, published guidance exists from bodies like WHO, the US FDA, and national health systems, and grounding AI governance in one of these sources is what distinguishes responsible adoption from an ungoverned experiment run on real patients. This is about having an actual, citable basis for how AI is governed in this hospital, not a vague sense that AI is probably being used responsibly.

WHAT GOOD LOOKS LIKE

- AI systems are genuinely introduced in line with applicable law, where it exists.
- Where no specific law exists, introduction is genuinely informed by recognized best-practice guidance.
- The hospital can identify the specific regulatory or guidance basis for a given AI system.

COMMON FAILURE MODES

- No reference to law or regulation has been made at all before adopting an AI tool.
- Guidance is vaguely cited without the hospital actually having reviewed or applied it.
- Nobody can say, when asked, what the governance basis for a given AI system actually is.

WORKED EXAMPLE

IN PRACTICE

A hospital that adopted an AI-assisted radiology triage tool with no formal governance review.

PHIG	BEFORE	The radiology department adopted an AI triage tool to flag urgent imaging findings, based on a colleague's recommendation at another facility. No one checked national regulatory requirements or reviewed any published governance guidance before go-live.
	ACTION	A governance review was retrospectively conducted, confirming the jurisdiction had no AI-specific medical device regulation yet in force, and formally adopting WHO's AI ethics and governance guidance as the hospital's reference framework, with a documented checklist applied to this and future AI tools.
	AFTER	The Monitor reviewed the governance checklist and confirmed the radiology lead could specifically name WHO's guidance as the basis for the tool's oversight. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether any national or regional AI-specific healthcare regulation currently applies.
2. Where none exists, formally adopt a recognized guidance source — WHO, FDA, or similar — as the hospital's reference.
3. Apply this basis as a documented checklist to every AI system currently in use.

The most common mistake: Assuming AI tools fall under general IT or medical device policy with no AI-specific governance basis actually identified or applied.

SELF-ASSESSMENT QUESTIONS

1. Is any AI system in clinical use genuinely introduced in line with applicable law or regulation on AI, where this exists? — *Real, verified compliance, not an assumption that general IT policy already covers AI-specific requirements.*
Evidence: Regulatory compliance review
2. Where no specific legislation exists, is the AI system's introduction genuinely informed by recognized best-practice

guidance, such as WHO's AI ethics and governance guidance? — A real, referenced guidance source, not an ad hoc decision with no external grounding.

Evidence: Documented guidance reference

3. Can the hospital identify, when asked, the specific regulatory or guidance basis for how a given AI system is governed? — A real, specific answer, not a vague assurance that AI use is “handled appropriately.”

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Guidance was reviewed once at adoption but hasn't been revisited as AI regulation evolves.** — This is a fast-moving regulatory area; periodic review matters.
- **A guidance source is named but hasn't actually been applied to this hospital's specific AI tools.** — Citing a source isn't the same as genuinely working through its application here.
- **Different departments have adopted different, uncoordinated governance approaches.**

IMPLEMENTATION PLAN

When	What
Week 1	Research applicable AI-specific regulation in the hospital's jurisdiction.
Week 2	Formally adopt a recognized guidance source if no binding regulation exists.
Week 3	Apply this basis as a checklist to every current AI system in clinical use.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Governance basis review	Reviews the documented regulatory or guidance basis for AI governance.
ASK	Staff interview	Asks the department using an AI tool to name its governance basis specifically.

- **Ask for the name of the specific law or guidance document governing a given AI tool.** — A vague answer reveals the governance basis isn't genuinely established, just assumed.
- **Check whether governance was reviewed at adoption only, or is genuinely kept current.** — AI regulation changes quickly; a static, one-time review may already be outdated.

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health: Guidance on Large Multi-Modal Models. Geneva: WHO; 2024.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

19.5

AI Systems Are Genuinely Monitored for Unintended Consequences

STANDARD

The hospital genuinely monitors and evaluates its AI systems — auditing results for over-diagnosis or missed diagnosis, tracking patient complaints related to AI-assisted care, and checking for other unintended consequences — not deploying an AI tool and assuming it works as intended with no real, ongoing scrutiny.

In plain terms: The hospital actually keeps checking whether its AI tools are working as expected — catching real problems like missed diagnoses or bias — not deploying a tool once and simply trusting it from then on.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

AI systems can fail in ways that aren't obvious at the point of use — a diagnostic tool trained on a different population than the one it's now serving can systematically miss certain presentations or over-flag others, and these patterns often only become visible through deliberate, ongoing monitoring rather than any single clinical

encounter. A hospital that treats AI output with the same unquestioning trust as a simple calculator is missing the genuine, documented risk that these systems carry: they can be confidently, consistently wrong in ways a single clinician reviewing a single case won't necessarily catch.

WHAT GOOD LOOKS LIKE • AI output is genuinely, regularly audited for over-diagnosis or missed diagnosis. • Patient complaints related to AI-assisted care are genuinely tracked and reviewed. • A documented instance exists of monitoring catching a real issue, with a genuine response.	COMMON FAILURE MODES • AI output is trusted with no ongoing audit of its actual accuracy. • Patient concerns about AI-assisted care are absorbed into general complaints with no distinct tracking. • No monitoring process has ever actually caught or flagged an issue.
---	--

WORKED EXAMPLE

IN PRACTICE <i>A hospital using an AI tool to flag abnormal lab results for urgent review.</i>	
BEFORE	The AI flagging tool had been running for a year with no formal audit of its accuracy. Nobody had checked whether it was correctly flagging genuinely abnormal results or missing anything it should have caught.
ACTION	A quarterly audit was introduced, comparing a sample of AI-flagged and non-flagged results against independent clinical review. The audit identified a pattern of missed flags for a specific result range, which was reported to the vendor and addressed in a subsequent system update.
AFTER	The Monitor reviewed the quarterly audit reports, including the documented missed-flag issue and the vendor's resulting fix. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Identify every AI system currently influencing clinical decisions.
2. Establish a periodic audit comparing AI output against independent clinical review for each.
3. Create a distinct channel for tracking patient concerns specifically related to AI-assisted care.

The most common mistake: Treating AI output as reliably correct by default, with no ongoing audit process ever established to actually test that assumption.

SELF-ASSESSMENT QUESTIONS

1. Is the output of AI-assisted diagnosis or care decisions genuinely audited for over-diagnosis or missed diagnosis, not assumed reliable without checking? — *Real, ongoing audit, not an assumption that AI accuracy requires no verification.*

Evidence: AI output audit records

2. Are patient complaints or concerns related to AI-assisted care genuinely tracked and reviewed? — *A real, specific tracking mechanism, not AI-related concerns absorbed into general feedback with no distinct visibility.*

Evidence: AI-specific complaint tracking log

3. Is there a documented instance where monitoring identified an issue with an AI system's performance, and a genuine response followed? — *A real, concrete example, not a monitoring process that has never actually caught anything in practice.*

Evidence: Issue identification and response record

COMMON REASONS FOR A PARTIAL ANSWER

- **Auditing happens but at too infrequent an interval to genuinely catch emerging patterns.** — Audit frequency should be genuinely matched to the clinical stakes of the AI system.
- **Monitoring exists but has never been genuinely independent of the AI system's own output.** — A real audit requires comparison against independent clinical judgment, not the system checking itself.
- **No issue has ever been identified, raising the question of whether monitoring is genuinely rigorous.**

When	What
Week 1	Identify every AI system currently influencing clinical decisions.
Week 2-3	Establish a periodic, independent audit process for each system.
Week 4	Create a distinct tracking mechanism for AI-related patient concerns.
Ongoing	Conduct audits on a genuine, defined schedule matched to clinical risk.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Audit record review	Reviews periodic AI output audits for genuine, independent comparison.
DOCUMENT	Issue response review	Looks for a real, documented instance of monitoring catching and addressing an issue.

SUPERVISOR TIPS

- **Ask to see the most recent AI audit and whether it found anything worth flagging.** — A genuinely rigorous audit occasionally finds something; one that never does merits scrutiny.
- **Confirm audits are conducted independently of the AI vendor, not solely by the vendor itself.** — Independent review is what gives the audit genuine credibility.

EVIDENCE BASE

US Food and Drug Administration. Artificial Intelligence and Machine Learning in Software as a Medical Device. Silver Spring: FDA; 2023.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

19.6

Staff Are Genuinely Consulted Before an AI System Is Introduced

STANDARD

Staff who will actually deliver care using a new AI system are genuinely consulted before it is introduced, to understand the practical implications and identify real training needs — not an AI tool rolled out to clinical staff with no engagement beyond a brief notification that it now exists.

In plain terms: Before a new AI tool goes live, the staff who will actually use it have had a real say — not just been told it’s coming, with their actual concerns and training needs never genuinely asked about.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

AI systems are genuinely disruptive to established clinical workflows in ways that are often invisible from outside the workflow itself — the staff actually doing the work know where friction will arise, what training will genuinely be needed, and what practical problems a system’s designers never anticipated. A hospital that introduces an AI tool through top-down announcement rather than real consultation loses this knowledge entirely, and frequently ends up with a tool staff quietly work around rather than genuinely adopt — undermining the very benefit the system was meant to deliver.

WHAT GOOD LOOKS LIKE

- Staff are genuinely consulted before, not after, an AI system’s introduction is finalized.
- Consultation genuinely identifies training needs, which are then actually delivered.
- Staff asked directly can describe having been

COMMON FAILURE MODES

- Staff learn about a new AI system only once the decision to adopt it is already final.
- Training needs are identified but never actually addressed before go-live.
- Staff describe the AI system as something that

WORKED EXAMPLE

IN PRACTICE	
A hospital introducing an AI-assisted clinical documentation tool.	
BEFORE	Physicians were informed by email that a new AI documentation assistant would go live the following month, with a link to a vendor-produced video. No consultation occurred, and when the tool launched, physicians found it didn't fit how they actually structured clinical notes, leading many to simply stop using it.
ACTION	A relaunch was planned with genuine physician consultation first — focus groups to understand actual documentation workflows, identifying specific friction points the tool needed to address, and physician-led training sessions rather than a vendor video.
AFTER	The Monitor interviewed physicians who could describe having been genuinely consulted before the relaunch, with specific examples of changes made based on their input. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Before finalizing any AI system decision, hold a genuine consultation session with the staff who will use it.
2. Ask directly what training they believe they'll need, not assume this centrally.
3. Deliver that training before go-live, not as an afterthought once problems emerge.

The most common mistake: Treating a notification email or vendor demo video as equivalent to genuine staff consultation.

1. Are staff who will actually use a new AI system genuinely consulted before its introduction, not informed only after the decision is finalized? — *Real, prior consultation, not a rollout announcement to staff with no genuine input sought.*

Evidence: Consultation session records

2. Does this consultation genuinely identify practical training needs, which are then actually addressed before go-live? — *Real, identified needs matched by real, delivered training, not a consultation that produces no follow-through.*

Evidence: Training needs assessment and delivery record

3. Can staff asked directly describe having been genuinely consulted about a recent AI system introduction? — *Tests whether consultation actually reached and registered with staff, not just whether it technically occurred.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Consultation happened with department leads but not the staff actually doing the work.** — Genuine consultation should reach the actual end users, not only their supervisors.
- **Training needs were identified but delivery was rushed or incomplete before go-live.** — Identification without genuine, adequate delivery leaves staff underprepared regardless.
- **Consultation occurred for one AI system but isn't yet a consistent practice.**

IMPLEMENTATION PLAN

When	What
Before any launch	Hold genuine consultation sessions with the actual staff who will use the system.
Following consultation	Document identified training needs and build a real delivery plan.
Before go-live	Complete training delivery, confirmed by staff feedback, not assumed sufficient.

Method	What	Detail
DOCUMENT	Consultation record review	Reviews records of genuine staff consultation before a recent AI system’s introduction.
ASK	Staff interview	Asks frontline staff directly whether they were genuinely consulted and how.

SUPERVISOR TIPS

- **Ask a frontline user, not a department head, whether they felt genuinely consulted.** — The actual end user’s experience is the real test of whether consultation reached them.
- **Ask for a specific example of something changed because of staff input.** — A concrete example distinguishes genuine consultation from a box-ticking exercise.

EVIDENCE BASE

Topol EJ. High-Performance Medicine: The Convergence of Human and Artificial Intelligence. Nature Medicine. 2019;25(1):44-56.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

19.7

Accountability for AI-Assisted Care Is Explicitly Defined

STANDARD

The hospital has genuinely considered and documented accountability arrangements for care and treatment delivered with AI support — who is responsible when an AI-assisted decision is wrong — not leaving this as an unexamined question until the first time it actually matters.

In plain terms: Everyone knows, in advance, who is actually responsible if an AI-supported decision turns out to be wrong — not a question nobody has thought through until it comes up for real, with a patient already affected.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

AI-assisted decisions sit in genuinely new territory for clinical accountability — a tool contributed to a decision, but a human clinician remains responsible for the care actually delivered, and that relationship needs to be explicit rather than assumed. Without clear, documented accountability, a safety incident involving AI-assisted care risks becoming a confused dispute about where responsibility actually lay, exactly when clarity matters most — for the affected patient, for the clinician involved, and for the hospital’s own ability to learn genuinely from what happened.

WHAT GOOD LOOKS LIKE

- Clinical accountability for AI-supported decisions is explicitly, clearly documented.
- Clinicians using AI-supported tools genuinely understand their own accountability.
- A defined process exists for reviewing accountability when an incident involves AI-assisted care.

COMMON FAILURE MODES

- Accountability for AI-assisted decisions has never been explicitly addressed or documented.
- Clinicians assume the AI system itself bears some responsibility, diffusing genuine accountability.
- No defined process exists for reviewing an incident where AI contributed to the decision.

WORKED EXAMPLE

IN PRACTICE

A hospital using an AI-assisted sepsis prediction tool with no documented accountability policy.

BEFORE

An AI tool flagged sepsis risk scores to nursing staff, who were expected to escalate high-risk patients. No policy explicitly stated whether responsibility for a missed escalation sat with the nurse, the ordering physician, or was assumed to be shared with the AI system itself.

ACTION

A clear accountability policy was documented: the AI tool is a decision-support input only, and the clinician reviewing the flag retains full clinical accountability for the escalation decision, with this explicitly taught in onboarding for the tool and confirmed through a staff sign-off.

AFTER

The Monitor reviewed the documented policy and interviewed a nurse who could clearly state her own accountability for escalation decisions, independent of the AI flag. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For each AI system in clinical use, explicitly document where clinical accountability sits.
2. Communicate this clearly to the staff who use the system, not leave it implicit.
3. Build a specific step into incident review processes for events involving AI-assisted care.

The most common mistake: Leaving accountability for AI-assisted decisions genuinely ambiguous, assuming it will become clear if and when it's ever actually tested by a real incident.

SELF-ASSESSMENT QUESTIONS

1. Is clinical accountability for a decision made with AI support explicitly documented, not left genuinely ambiguous between clinician and system? — *A real, clear answer, not an assumption that responsibility will sort itself out if something goes wrong.*

Evidence: Documented accountability policy

2. Do clinicians using AI-supported tools genuinely understand their own accountability for the final care decision? — *Real, demonstrated staff understanding, not a policy nobody using the tool has actually internalized.*

Evidence: Staff interview, training sign-off

3. Is there a defined process for reviewing accountability when an AI-assisted decision contributes to a safety incident? — *A real, usable process, not a question left entirely open until an actual incident*

COMMON REASONS FOR A PARTIAL ANSWER

- **A policy exists but hasn't actually been communicated to or understood by frontline staff.** — A documented policy nobody using the tool actually knows about doesn't meet the real intent.
- **Accountability is clear for one AI system but undefined for others in use.** — Genuine coverage should extend consistently to every AI system influencing care.
- **General incident review exists but has no specific step addressing AI involvement.**

IMPLEMENTATION PLAN

When	What
Week 1	Document explicit accountability for each AI system currently in clinical use.
Week 2	Communicate this clearly to all relevant staff, with sign-off confirmation.
Week 3	Add an AI-specific step to the hospital's incident review protocol.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Accountability policy review	Reviews the documented accountability policy for AI-assisted care.
ASK	Staff interview	Asks a clinician to describe their own accountability when using an AI-supported tool.

SUPERVISOR TIPS

- **Ask a clinician directly: if the AI flagged something wrong, who is responsible?** — A confident, specific answer reveals genuine understanding, not assumed clarity.
- **Check whether the incident review process has an actual AI-specific step, not a generic one.** — A specific step signals the hospital has genuinely thought this through in advance.

European Commission. Ethics Guidelines for Trustworthy Artificial Intelligence. Brussels: European Commission; 2019.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

19.8 Patients Are Genuinely Informed When Their Care Involves AI

STANDARD

A patient whose care involves an aspect delivered with AI system support is genuinely informed of this — not left to assume every decision was made by a human clinician alone, with disclosure treated as optional rather than a genuine, standard part of informed care.

In plain terms: If AI is actually involved in part of a patient's care, they're genuinely told — not left to assume a human made every decision alone.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A patient's genuine right to understand their own care includes knowing, in plain terms, when a decision affecting them was shaped by an AI system rather than a clinician's judgement alone. This isn't a formality — a patient who genuinely knows AI was involved can ask informed questions, seek a second opinion with that context, or simply understand their care more completely. Disclosure buried in a general consent form a patient never actually reads does not meet this bar.

WHAT GOOD LOOKS LIKE

- Patients are genuinely informed when AI is involved in their care.
- Disclosure is genuinely understandable, in plain language.

COMMON FAILURE MODES

- AI disclosure is buried in a general consent form, technically present but never genuinely read or understood.

WORKED EXAMPLE

IN PRACTICE

A hospital using an AI-assisted imaging triage tool.

BEFORE

AI's role was mentioned only in a lengthy general consent document, which patients signed without genuine awareness that an AI tool had actually been involved in their specific case.

ACTION

A brief, plain-language note was added to the patient's own results discussion: "An AI-assisted tool helped flag areas for the radiologist to review closely."

AFTER

The Monitor interviewed a patient who could genuinely confirm they understood AI had been involved. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a brief, plain-language disclosure point at the moment results or care decisions involving AI are actually discussed with the patient.

The most common mistake: Treating a line buried in a general consent form as genuine disclosure, when the patient never actually registers it.

SELF-ASSESSMENT QUESTIONS

1. Is a patient genuinely informed when AI is involved in their care?

— *Real, standard disclosure.*

Evidence: Disclosure protocol

2. Is this disclosure genuinely understandable, not buried in technical language? — *A real, plain-language explanation.*

Evidence: Disclosure wording sample

A real, concrete confirmation.
Evidence: Patient interview

COMMON REASONS FOR A PARTIAL ANSWER

- Disclosure exists in a consent form but patients genuinely cannot recall or explain it when asked directly.

IMPLEMENTATION PLAN

When	What
Week 1-2	Draft plain-language disclosure wording for each AI-assisted care point and train staff to deliver it.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Patient interview	Asks a patient whether they were genuinely told AI was involved in their care.

SUPERVISOR TIPS

- Ask a patient directly rather than relying on the consent form’s existence alone.

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health: Guidance on Large Multi-Modal Models. Geneva: WHO; 2024.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

- ← Hospital Standards — all standards
- Self-assess against these criteria →
- ← Standard 18 — Sustainable Care
- Standard 20 — Supporting the Care Workforce →

ASF STANDARDS · HOSPITAL · STANDARD 20

Standard 20 — Supporting the Care Workforce

8 criteria · 3 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 8, 6th Edition

CRITERIA IN THIS STANDARD

- 20.1 — Every Member of the Workforce Is Genuinely Credentialed for Their Actual Role
- 20.2 — Ongoing Competency Is Genuinely, Regularly Evaluated
- 20.3 — Staff Have Genuine Access to Ongoing Education and Skill Development
- 20.4 — Workforce Health and Safety Is Genuinely Protected
- 20.5 — Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved
- 20.6 — Staff Are Genuinely Protected From Violence and Aggression
- 20.7 — Workforce Feedback Is Genuinely Gathered and Acted On
- 20.8 — Sick Leave and Attrition Data Genuinely Inform Organisational Learning
- 20.9 — Equality, Diversity and Inclusion Across the Workforce Are Genuinely Monitored

Every Member of the Workforce Is

20.1 Genuinely Credentialed for Their Actual Role

CORE

Every member of the workforce — employed staff, independent practitioners with privileges, contracted care providers, and volunteers alike — has genuine assurance of the qualifications, licences, and scope of practice their role requires, and does not practise beyond that scope — not credentialing confined to directly-employed clinical staff while contracted and volunteer roles go unchecked.

In plain terms: Everyone who actually delivers or supports care here — whether they’re on the payroll, privileged independently, working for a contracted agency, or volunteering — has had their real qualifications genuinely checked, not just the people on the hospital’s own staff roster.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Patients experience care from a hospital’s entire workforce, not just its directly-employed staff — the contracted agency nurse covering a night shift, the independent specialist with admitting privileges, the volunteer supporting a ward round, all deliver or touch patient care in real, meaningful ways. A credentialing process that rigorously checks employed staff but quietly assumes contracted agencies or volunteer coordinators have already done their own due diligence creates exactly the kind of gap patients never see until something goes wrong. This is marked Core because an uncredentialed person delivering care, regardless of their employment category, is a direct, serious patient safety risk — the category of their employment relationship with the hospital changes nothing about that risk.

WHAT GOOD LOOKS LIKE

- Genuine credential assurance extends to

COMMON FAILURE MODES

- Contracted agency staff are assumed pre-vetted

- Each person's actual scope of practice is genuinely verified against real qualifications.
- A real, defined process exists if someone is found practising outside their verified scope.

- Volunteers assisting with patient-facing tasks have never had their background or competency checked.
- A scope-of-practice mismatch is identified but no real corrective action follows.

WORKED EXAMPLE

IN PRACTICE

A hospital relying on an agency for night-shift nursing coverage.

BEFORE	Agency nurses covering night shifts were assumed to be fully vetted by their staffing agency. The hospital's own credentialing office had never independently verified a single agency nurse's licence directly with the issuing body.
ACTION	The credentialing office extended its direct-verification process to cover every agency nurse before their first shift, confirmed via the same issuing-body check used for employed staff, with a log maintained of verification dates and renewal tracking.
AFTER	The Monitor reviewed the verification log and confirmed every currently active agency nurse had a documented, directly-verified credential on file. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every category of workforce delivering or supporting care — employed, privileged, contracted, volunteer.
2. Confirm direct credential verification genuinely extends to each category, not employed staff alone.

The most common mistake: Trusting a contracted agency's own vetting claims without the hospital ever independently verifying credentials itself.

SELF-ASSESSMENT QUESTIONS

1. Does genuine credential assurance extend to every category of workforce — employed, privileged, contracted, and volunteer — not employed clinical staff alone? — *Real, consistent coverage across every workforce category, not a gap for contracted or volunteer roles.*

Evidence: Credential verification records by workforce category

2. Is each person's actual scope of practice genuinely verified against their real qualifications, not assumed appropriate for the role they've been assigned? — *A specific, documented match, not an informal assumption that the role and the person's qualifications align.*

Evidence: Scope-of-practice verification record

3. Is there a real, defined process if someone is found practising outside their verified scope? — *A genuine corrective process, not a gap identified with no actual response.*

Evidence: Scope-mismatch correction procedure

COMMON REASONS FOR A PARTIAL ANSWER

- **Credentialing is rigorous for clinical staff but absent or minimal for non-clinical volunteers.** — Even non-clinical roles in patient-facing areas warrant some real, defined verification.
- **Verification happens at initial engagement but isn't repeated as credentials expire.** — A credential verified once, years ago, with no renewal check, is no longer a genuine assurance.
- **A corrective process exists but has never actually been tested or used.**

IMPLEMENTATION PLAN

When	What
Week 1	Map every workforce category currently engaged by the hospital.
Week 2-3	Extend direct credential verification to any category currently relying on third-party assurance.

Ongoing	Track renewal dates and reconfirm credentials on a defined schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Credential record review	Reviews verification records across every workforce category, not employed staff alone.
ASK	Credentialing office interview	Asks how contracted and volunteer credentials are specifically verified.

SUPERVISOR TIPS

- **Ask specifically about the hospital’s most recently engaged contracted or agency worker.** — A recent, specific example reveals whether the process genuinely functions in practice.
- **Check whether volunteer credentialing exists at all, not just assume it’s covered by employed-staff processes.** — Volunteers are the category most often overlooked entirely.

EVIDENCE BASE

The Joint Commission. Credentialing and Privileging Standards for Hospitals. Oakbrook Terrace: TJC; 2023.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

20.2

Ongoing Competency Is Genuinely,
Regularly Evaluated

CORE

The continued competency and ongoing performance of every workforce member is genuinely, regularly evaluated against their actual job description and scope of practice — not competency assumed to remain current indefinitely once initial credentialing is complete.

In plain terms: Staff competency keeps getting genuinely checked throughout someone’s time here, not just verified once when they’re hired and then never looked at again.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Initial credentialing confirms someone was qualified at the point of hire — it says nothing about whether their skills have kept pace with evolving clinical practice, whether a period away from certain procedures has eroded proficiency, or whether their actual current performance matches what their role requires. This is marked Core because the gap between “was qualified once” and “is genuinely competent now” is exactly where patient safety risk accumulates silently — a clinician can hold a fully valid, unexpired licence while their actual day-to-day performance has genuinely declined, and only real, ongoing evaluation catches that gap before it affects a patient.

WHAT GOOD LOOKS LIKE

- Ongoing competency is genuinely evaluated on a real, defined schedule.
- Evaluation genuinely covers the person’s actual current job description and scope.
- A genuine performance gap triggers a real, defined response.

COMMON FAILURE MODES

- Competency evaluation happened at hiring and has never been genuinely repeated since.
- Evaluations use a generic form unrelated to the person’s actual current duties.
- A real performance gap is identified but produces no genuine follow-up action.

WORKED EXAMPLE

IN PRACTICE

A hospital where annual performance reviews had become a purely administrative formality.

BEFORE

Annual reviews consisted of a generic checklist signed by a supervisor with minimal genuine engagement, unrelated to the specific clinical

competencies each role actually required. No

review had ever resulted in a documented performance gap or corrective action.

ACTION

Role-specific competency evaluation criteria were developed for each major clinical role, with direct observation components added alongside the administrative review, and a defined corrective pathway established for any identified gap.

AFTER

The Monitor reviewed recent evaluations and found role-specific, substantive content, including one documented instance of a competency gap identified and genuinely addressed through targeted retraining. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether current performance reviews are genuinely role-specific or purely generic.
2. Build role-specific competency criteria for at least the highest-risk clinical roles first.
3. Define a real corrective pathway before the first gap is actually identified.

The most common mistake: Treating an annual review as a purely administrative, box-ticking exercise disconnected from any genuine assessment of current clinical competency.

SELF-ASSESSMENT QUESTIONS

1. Is ongoing competency genuinely evaluated on a real, defined schedule, not assumed to persist from initial hiring? — *A real, periodic evaluation, not a one-time check treated as permanently sufficient.*

Evidence: Competency evaluation schedule and records

2. Does this evaluation genuinely cover the person's actual current job description and scope, not a generic check unrelated to their real duties? — *A specific, role-relevant evaluation, not a generic form applied uniformly regardless of actual role.*

Evidence: Role-specific evaluation criteria

3. When an evaluator identifies a genuine performance gap, is there a real, defined response? — *A genuine corrective process, not a gap noted with no actual follow-through.*
Evidence: Performance gap correction record

COMMON REASONS FOR A PARTIAL ANSWER

- **Evaluation occurs but relies entirely on self-report with no independent verification.** — Genuine evaluation should include some form of independent observation or review.
- **Evaluation is thorough for some roles but minimal or absent for others.** — Consistent, genuine coverage should extend across the whole workforce.
- **Gaps are identified but corrective action is inconsistently followed through.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Review current evaluation process for genuine, role-specific substance.
Week 3-4	Build or strengthen role-specific competency criteria for key clinical roles.
Ongoing	Conduct evaluations on schedule, with a genuine corrective pathway for gaps.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Evaluation record review	Reviews recent competency evaluations for genuine, role-specific substance.
DOCUMENT	Corrective action review	Looks for a real, documented instance of a gap identified and addressed.

SUPERVISOR TIPS

- **Ask to see an evaluation that actually identified a real gap, not just a clean pass.** — A genuinely rigorous process occasionally finds something; one that never does merits scrutiny.
- **Check whether evaluation content is genuinely specific to the role, not a generic form.** — Role-specificity is the clearest sign of a genuine, substantive evaluation process.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

20.3

Staff Have Genuine Access to Ongoing Education and Skill Development

STANDARD

Every workforce member has genuine access to ongoing education — formal courses and training sessions, whether internal or external — to maintain the performance their role requires and genuinely develop their skills further, not education treated as a one-time induction event with nothing meaningful offered afterward.

In plain terms: Staff can actually keep learning and developing after they’re hired — real courses and training they can genuinely access — not a single orientation session treated as the end of their professional development.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Medicine and care practice evolve continuously, and staff whose education effectively ends at hiring inevitably fall behind, regardless of how well-trained they were initially. Genuine ongoing education isn’t a perk — it’s how a hospital’s actual standard of care stays current rather than slowly drifting toward whatever was best practice when today’s longest-serving staff were originally trained. A hospital that offers education in name but makes it practically inaccessible — no coverage to attend, no budget, no real encouragement — has not actually met this intent, however generous the stated policy looks on paper.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Every workforce member has genuine, ongoing access to education beyond induction.
- Genuine opportunities for real skill development are offered, not only minimum compliance training.
- Staff asked directly can describe a real education opportunity actually taken.

- Education exists as a policy but staff have no real practical way to attend it.
- Only mandatory compliance training is offered, with no genuine development opportunity.
- Staff cannot name any education they've actually accessed in the past year.

WORKED EXAMPLE

IN PRACTICE	
A hospital where continuing education existed as policy but rarely in practice.	
BEFORE	The staff handbook stated a commitment to ongoing professional development, but no budget was allocated, no shift coverage was arranged to allow attendance, and nurses interviewed could not recall any training beyond annual mandatory compliance modules.
ACTION	A modest annual education budget was allocated per department, with a defined process for requesting coverage to attend external courses, and quarterly internal training sessions were scheduled with protected time built into staffing rosters.
AFTER	The Monitor interviewed three nurses who could each describe a specific recent education opportunity they had genuinely taken, including one who had attended an external course with hospital-arranged coverage. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask staff directly what education they've actually accessed in the past year — listen to the gap.
2. Allocate even a modest, real budget and protected time for genuine education access.

The most common mistake: A generous-sounding education policy with no real budget, coverage, or practical access behind it.

SELF-ASSESSMENT QUESTIONS

1. Does every workforce member have genuine, ongoing access to education beyond initial induction? — *Real, continuing access, not training treated as a one-time event at hiring.*

Evidence: Education access policy and budget
2. Are genuine opportunities for skill development and extension offered, not only the minimum required to maintain current performance? — *Real development opportunities, not only remedial or compliance-driven training.*

Evidence: Training calendar, course offerings
3. Can staff asked directly describe a genuine education opportunity they've taken in the past year? — *A real, specific example, not a theoretical entitlement nobody actually uses.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Education access exists but mainly for senior staff, not consistently across all roles.** — Genuine access should extend across the workforce, not concentrate among the most senior.
- **Budget exists but shift coverage to actually attend training rarely materializes.** — A budget without practical coverage doesn't translate into real, usable access.
- **Internal training happens but is rarely well-attended due to competing demands.**

IMPLEMENTATION PLAN

When	What
Week 1	Survey staff on actual education access over the past year.
Week 2-3	Allocate real budget and build a coverage-request process for external courses.
Week 4	Schedule recurring internal training with protected staffing time.

Method	What	Detail
ASK	Staff interview	Asks staff to describe a specific, real education opportunity taken recently.
DOCUMENT	Budget and calendar review	Reviews allocated education budget and actual training calendar.

SUPERVISOR TIPS

- **Ask a junior or newer staff member, not only senior staff, about education access.** — Genuine, equitable access should extend across seniority levels, not concentrate at the top.
- **Check whether training time is actually protected in rosters, not just nominally offered.** — Protected time is what distinguishes real access from a theoretical entitlement.

EVIDENCE BASE

World Health Organization. Global Strategy on Human Resources for Health: Workforce 2030. Geneva: WHO; 2016.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

20.4 Workforce Health and Safety Is Genuinely Protected CORE

The hospital genuinely protects the health and safety of its workforce while they carry out their duties — required vaccinations, personal protective equipment, prevention of manual handling and needlestick injuries — not staff safety treated as secondary to patient safety rather than an equally real, equally protected concern.

In plain terms: The people working here are genuinely kept safe while doing their jobs — real protective equipment actually used, real steps taken to prevent injury — not staff safety treated as an afterthought behind patient safety.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A hospital's capacity to deliver safe patient care depends entirely on a workforce that is itself healthy, protected, and able to work safely — an injured, exposed, or unprotected workforce cannot reliably deliver safe care, no matter how well-designed the patient-facing standards are. This is marked Core because occupational injuries in healthcare — needlestick exposures, manual handling injuries, infections from inadequate protection — are genuinely common, genuinely preventable with real protective measures, and genuinely consequential both for the individual staff member and for the hospital's capacity to maintain safe staffing and continuity of care.

WHAT GOOD LOOKS LIKE

- Personal protective equipment is genuinely available and actually, consistently used.
- Genuine, specific measures prevent manual handling and needlestick injuries.
- Required staff vaccinations are genuinely tracked and current, with real verification.

COMMON FAILURE MODES

- PPE is available but inconsistently worn, with no genuine monitoring of actual use.
- A safety policy exists with no concrete, real measures behind it.
- Vaccination status is assumed current with no actual tracking or verification.

WORKED EXAMPLE

IN PRACTICE

A hospital with a rising rate of unreported needlestick injuries.

BEFORE

Safety-engineered needle devices were available in some departments but not others, and staff frequently reverted to older equipment under time pressure. Needlestick incidents were suspected to be under-reported, with no real tracking system in place.

Safety-engineered devices were standardized across every department, a genuine, blame-free reporting system was introduced with a simple one-page form, and staff vaccination records were audited and brought current with a tracking system for future renewals.

AFTER

The Monitor observed safety-engineered devices in consistent use across multiple departments, reviewed the needlestick reporting log showing genuine, non-punitive reporting activity, and confirmed vaccination tracking was current for a sample of staff files. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Audit current PPE availability and actual, observed use across departments.
2. Build a simple, genuinely non-punitive reporting system for occupational injuries.
3. Audit and establish real tracking for staff vaccination currency.

The most common mistake: Assuming PPE availability is equivalent to PPE actually being consistently used, without any real, observed verification.

SELF-ASSESSMENT QUESTIONS

1. Is personal protective equipment genuinely available and actually used by staff, not available in theory but inconsistently worn in practice? — *Real, observed use, not equipment present but not actually worn.*

Evidence: PPE availability and observed compliance

2. Are genuine, specific measures in place to prevent manual handling and needlestick injuries, not a general safety policy with no concrete protective measures? — *Real, specific protective measures, not a policy statement with no actual practice behind it.*

Evidence: Safety-engineered equipment, training records

3. Are required staff vaccinations genuinely tracked and current, not assumed complete with no real verification? — *Real, verified tracking,*

COMMON REASONS FOR A PARTIAL ANSWER

- **Safety measures are strong in some departments but inconsistent across the whole hospital.** — Genuine protection should extend consistently, not vary significantly by department.
- **Reporting systems exist but staff don't genuinely trust them as non-punitive.** — Real psychological safety around reporting is necessary for the data to actually be complete.
- **Vaccination tracking exists but hasn't been genuinely audited for completeness recently.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit PPE availability and actual use across all departments.
Week 2	Standardize safety-engineered equipment where gaps exist.
Week 3	Audit and establish current vaccination tracking.
Ongoing	Monitor injury and vaccination data for real, ongoing improvement.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Direct observation	Observes actual PPE use during a ward walkthrough, not relying on policy alone.
DOCUMENT	Vaccination tracking review	Reviews a sample of staff files for current, verified vaccination status.

SUPERVISOR TIPS

- **Observe PPE use directly on a ward walkthrough, don't rely on reported compliance alone.** — Direct observation is the clearest test of whether protection is genuinely consistent.
- **Ask a staff member whether they'd genuinely feel safe reporting a needlestick injury.** — Real psychological safety around reporting is as important as the reporting system itself.

World Health Organization. Health Worker Safety Charter. Geneva: WHO; 2020.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

20.5

Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved

STANDARD

A genuine process exists for the investigation and resolution of workplace issues raised by workforce members — including whistleblowing concerns about organisational wrongdoing — with real protection from adverse treatment for those who raise them, not a grievance process that exists on paper with no real follow-through or genuine protection.

In plain terms: When staff raise a concern — about management, fairness, safety, or wrongdoing — it actually gets looked into and resolved, and the person who raised it is genuinely protected, not quietly disadvantaged for having spoken up.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Staff are often the first to notice problems — unsafe practices, unfair treatment, organisational wrongdoing — and a hospital that lacks a genuine, trusted channel for raising these concerns loses that early-warning capacity entirely. Worse, staff who don't trust that raising a concern is safe will often simply stay silent rather than risk retaliation, meaning real problems go unaddressed until they surface in a much more serious way. Genuine whistleblower protection isn't a box-ticking policy clause — it's what determines whether the hospital actually hears about problems while they're still manageable.

- A genuine, accessible process exists for raising workplace issues, including whistleblowing concerns.
- Real, documented evidence shows raised issues lead to genuine investigation and resolution.
- Staff who raise concerns are genuinely protected from adverse treatment.

- A grievance process exists on paper but staff don't know how to actually use it.
- Concerns are received but rarely lead to any documented resolution.
- Staff who have raised concerns describe real or perceived retaliation afterward.

WORKED EXAMPLE

IN PRACTICE

A hospital where a formal grievance policy existed but was rarely used.

BEFORE

A grievance policy existed in the staff handbook, but interviewed staff were unclear how to actually use it, and no grievance had been formally logged in over a year despite informal complaints clearly circulating among staff.

ACTION

A clear, accessible reporting channel was established — including an option to report outside the immediate management chain — with a written non-retaliation commitment signed by all managers and a defined response timeframe for every concern raised.

AFTER

The Monitor reviewed a genuine log of concerns raised and resolved over the following six months, and interviewed staff who described confidence that raising a concern would not result in retaliation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask staff privately whether they know how to raise a workplace concern and would feel safe doing so.

The most common mistake: Assuming a low number of formal grievances reflects genuine staff satisfaction, when it more often reflects a lack of trust in the process.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, accessible process for staff to raise workplace issues, including whistleblowing concerns? — *A real, known process, not a theoretical right with no practical, accessible channel.*

Evidence: Grievance/whistleblowing process documentation

2. Is there real, documented evidence that raised issues lead to genuine investigation and resolution? — *Genuine follow-through, not a process that receives concerns without acting on them.*

Evidence: Issue resolution log

3. Are staff who raise concerns genuinely protected from adverse treatment, not merely told they are? — *Real, demonstrated protection, not a stated non-retaliation policy with no actual confidence behind it.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A process exists but routes every concern through the immediate manager, including about that manager.** — Genuine accessibility requires a route that doesn't depend on the person the concern may be about.
- **Resolution happens but isn't genuinely documented or tracked over time.** — Real evidence of follow-through requires an actual record, not informal resolution nobody can verify.
- **Staff are aware of the policy but still express real hesitation about using it.**

IMPLEMENTATION PLAN

When	What
Week 1	Survey staff confidentially on their awareness and trust in the current process.

When	What
Week 2	Build or strengthen a reporting channel independent of the immediate management chain.
Week 3	Issue and communicate a genuine, specific non-retaliation commitment.
Ongoing	Track and document every concern raised through to genuine resolution.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Resolution log review	Reviews the actual log of workplace concerns raised and their documented resolution.
ASK	Staff interview	Asks staff directly whether they would feel safe raising a concern without retaliation.

SUPERVISOR TIPS

- **Ask staff privately whether they know how to raise a concern outside their direct manager.** — A confident, specific answer reveals genuine accessibility, not just policy existence.
- **Treat a very low number of logged concerns as worth investigating, not automatically reassuring.** — Silence often reflects distrust in the process rather than genuine absence of concerns.

EVIDENCE BASE

International Labour Organization. Violence and Harassment Convention, 2019 (No. 190). Geneva: ILO; 2019.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

20.6

Staff Are Genuinely Protected From Violence and Aggression

STANDARD

The hospital takes genuine, concrete steps to protect staff from violence and aggression — whether from patients, visitors, or other staff — ranging from verbal abuse and

violence treated as an unavoidable, unaddressed feature of healthcare work.

In plain terms: Real, specific steps are taken to keep staff safe from aggression and violence at work — not an assumption that getting shouted at or worse is just part of the job in healthcare.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Healthcare workers experience workplace violence at genuinely elevated rates compared to many other professions, and a culture that treats this as an unavoidable cost of the job — rather than a real, addressable safety issue — leaves staff exposed to serious harm with no real institutional response. The consequences extend well beyond the immediate incident: staff who don't feel protected report higher burnout, higher attrition, and reduced willingness to engage fully with challenging patients or situations, ultimately affecting the quality of care the hospital can deliver.

WHAT GOOD LOOKS LIKE

- Genuine, specific protective measures exist — de-escalation training, alarms, security response.
- Incidents of violence or aggression toward staff are genuinely tracked and reviewed.
- Staff can describe a real, specific instance where a protective measure genuinely worked.

COMMON FAILURE MODES

- A general safety policy exists with no concrete protective measures behind it.
- Incidents of aggression toward staff go unrecorded, treated as routine and unworthy of tracking.
- Protective measures exist on paper but have never actually been tested in a real situation.

WORKED EXAMPLE

IN PRACTICE

A hospital emergency department with frequent, unrecorded verbal abuse incidents.

BEFORE

Emergency department staff regularly experienced verbal abuse and occasional physical aggression from distressed patients and visitors, but these incidents were rarely formally reported, treated by staff as simply part of working in emergency medicine.

ACTION

De-escalation training was delivered to all emergency department staff, panic alarms were installed at key workstations with a defined security response protocol, and a simple, fast incident-logging system was introduced specifically for aggression incidents.

AFTER

The Monitor reviewed the incident log showing genuine, increased reporting activity, confirmed panic alarms were tested and functional, and interviewed a nurse who described a specific recent incident where the alarm system brought a genuine, timely security response. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask staff in high-risk areas directly about their real experience of aggression at work.
2. Introduce a simple, fast incident-logging system specific to violence and aggression.
3. Prioritize de-escalation training and a basic alarm/security response for the highest-risk areas first.

The most common mistake: Normalising verbal abuse and aggression as an unavoidable part of healthcare work, resulting in chronic under-reporting that masks the real scale of the issue.

SELF-ASSESSMENT QUESTIONS

1. Are genuine, specific measures in place to protect staff from violence and aggression, not a general policy with no concrete protective steps? — *Real, specific measures* — *de-escalation training,*

Evidence: Protective measure documentation

2. Are incidents of violence or aggression toward staff genuinely tracked and reviewed, not treated as isolated, unrecorded events?

— *Real, systematic tracking, not incidents that go unrecorded and therefore unaddressed at a pattern level.*

Evidence: Aggression incident log

3. Can staff describe a real, specific instance where a protective measure genuinely worked as intended? — *A real, concrete example, not protective measures that exist only in policy, untested in practice.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Protective measures exist in high-risk areas like emergency but not elsewhere in the hospital.** — Aggression risk, while concentrated in some areas, genuinely isn't confined to them alone.
- **Incidents are logged but rarely reviewed for patterns or used to inform real changes.** — Logging without genuine review doesn't translate into actual improvement.
- **Staff know measures exist but have never personally seen them actually used.**

IMPLEMENTATION PLAN

When	What
Week 1	Survey staff in highest-risk areas about real experience of aggression.
Week 2	Introduce a simple, specific incident-logging system for aggression events.
Week 3-4	Deliver de-escalation training and install basic alarm response in priority areas.
Ongoing	Review logged incidents for patterns and extend measures as needed.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Incident log review	Reviews the aggression incident log for genuine, ongoing tracking and review.

Method	What	Detail
ASK	Staff interview	Asks staff for a real, specific example of a protective measure working.

SUPERVISOR TIPS

- **Ask staff in a high-risk area directly about their real, recent experience, not just policy awareness.** — Direct, specific accounts reveal whether protection is genuine, not just documented.
- **Test a panic alarm or security response mechanism directly if possible.** — A functioning test is the clearest confirmation that protective measures genuinely work.

EVIDENCE BASE

World Health Organization. Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva: WHO/ILO/ICN/PSI; 2002.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

20.7 Workforce Feedback Is Genuinely Gathered and Acted On

STANDARD

The hospital has a genuine, systematic approach to gathering feedback from its workforce about their experience of working there, with real analysis of trends and a genuine, implemented response — not feedback collected occasionally with no real pattern of actual improvement resulting from it.

In plain terms: Staff get genuinely asked how working here actually is, their answers get really looked at for patterns, and real changes happen as a result — not a survey sent out once that nobody ever does anything with.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

Staff hold genuine, direct knowledge of what actually makes working at the hospital better or worse — information leadership often cannot access any other way. A hospital that gathers this feedback but never genuinely acts on it quickly teaches staff that the exercise is pointless, which erodes response rates and honesty in future surveys, compounding the original problem. Systematic, genuinely acted-upon feedback is what distinguishes an organisation that is actually learning from its own workforce from one merely performing the motions of listening.

WHAT GOOD LOOKS LIKE

- Workforce feedback is genuinely gathered on a systematic, recurring basis.
- Collected feedback is genuinely analysed for trends, not simply filed.
- A documented instance exists of feedback genuinely leading to an implemented change.

COMMON FAILURE MODES

- A single historical survey exists with no recurring collection since.
- Feedback is collected but never genuinely analysed or reported on.
- No visible change has ever resulted from any feedback exercise.

WORKED EXAMPLE

IN PRACTICE

A hospital whose last staff satisfaction survey was conducted three years earlier.

BEFORE

A staff satisfaction survey had been conducted once, three years prior, with results never formally shared back with staff and no documented changes resulting from it. Staff interviewed had largely forgotten the survey ever occurred.

ACTION

An annual survey cycle was established, with

results genuinely analysed for department-level trends, shared back with staff in a town hall, and specific actions committed to and tracked — including a staffing adjustment in a department that had reported high workload stress.

AFTER

The Monitor reviewed the most recent survey analysis and the resulting staffing adjustment, and interviewed staff who could describe the change as having genuinely resulted from the feedback they provided. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Establish even a simple, brief annual or biannual staff feedback survey.
2. Commit to genuinely analysing and sharing results back with staff, whatever they show.
3. Identify and implement at least one visible change based on the first round of real feedback.

The most common mistake: Running a feedback survey once, with no recurring cycle and no genuine, visible action resulting from it, which teaches staff the exercise doesn't matter.

SELF-ASSESSMENT QUESTIONS

1. Is workforce feedback genuinely gathered on a systematic, recurring basis — satisfaction surveys, exit interviews, consultations? — *Real, ongoing collection, not a single historical survey treated as sufficient indefinitely.*

Evidence: Survey cycle schedule and records

2. Is collected feedback genuinely analysed for trends, not simply filed without real examination? — *A real, documented analysis process, not raw feedback collected and left unexamined.*

Evidence: Trend analysis report

3. Is there a documented instance where workforce feedback genuinely led to an implemented change? — *A real, concrete example, not a feedback process that has never actually produced a*

COMMON REASONS FOR A PARTIAL ANSWER

- **Feedback is collected and analysed but never actually shared back with staff.** — Staff need to see that their input was genuinely heard, not just internally processed.
- **Exit interviews happen informally but aren't systematically recorded or analysed.** — Genuine analysis requires consistent, structured data, not scattered informal conversations.
- **Changes are made but are never explicitly connected back to the feedback that prompted them.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Design and launch a staff feedback survey, even a brief one.
Week 3-4	Analyse results for genuine trends and share findings back with staff.
Ongoing	Commit to a recurring cycle and track specific changes resulting from feedback.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Survey cycle review	Reviews the recurring survey schedule and trend analysis reports.
ASK	Staff interview	Asks staff whether they've seen a genuine change result from feedback they gave.

SUPERVISOR TIPS

- **Ask a staff member for a specific example of a change made because of workforce feedback.** — A real, specific example is the clearest test that feedback genuinely translates into action.
- **Check whether survey results were ever actually shared back with staff, not just internally reviewed.** — Transparency about results is part of what makes the process genuinely trusted.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

Sick Leave and Attrition Data

20.8 Genuinely Inform Organisational Learning

STANDARD

The hospital genuinely monitors and analyses data on staff sick leave and the reasons people leave, using this data to inform real organisational learning and genuine changes in practice that support workforce wellbeing and retention — not attrition treated as an unexamined, unavoidable cost of doing business.

In plain terms: The hospital actually looks at why staff get sick or leave, and genuinely uses what it learns to make things better — not treating turnover and absence as background noise nobody ever really investigates.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Patterns in sick leave and attrition are rarely random — a department with persistently high sick leave or unusually fast staff turnover is very often signalling something genuinely wrong: unsustainable workload, poor management practice, inadequate safety protection, or burnout the organisation hasn't yet recognised. A hospital that tracks these numbers purely for administrative or financial reporting, without genuinely analysing what they reveal, misses one of the clearest, most data-driven early warning signals available about its own organisational health — and loses the chance to address real problems before they compound into a genuine staffing crisis.

- Staff sick leave data is genuinely monitored and analysed, not simply recorded.

- The genuine reasons staff leave are actually captured, not assumed or left uninvestigated.
- A documented instance exists where this data genuinely informed a real, implemented change.

- Sick leave data is recorded for payroll purposes only, with no genuine pattern analysis.

- Exit interviews, if conducted at all, produce no real, systematically captured reasons.
- No change has ever resulted from reviewing this data, regardless of what it might show.

WORKED EXAMPLE

IN PRACTICE	
A hospital with unusually high nursing turnover in one specific department.	
BEFORE	A particular ward had lost nearly half its nursing staff over eighteen months, but this had never been flagged as unusual or specifically investigated — turnover was tracked hospital-wide only, obscuring the department-level pattern entirely.
ACTION	Department-level attrition tracking was introduced, immediately surfacing the pattern. Genuine exit interviews were conducted with recent leavers from that ward, revealing a consistent theme of unsustainable workload linked to a specific staffing ratio decision made a year earlier.
AFTER	The Monitor reviewed the department-level attrition data, the exit interview themes, and the subsequent staffing ratio adjustment made in direct response. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Break down existing sick leave and attrition data to department level, not only hospital-wide.

3. Review this data on a real, recurring schedule, specifically looking for departmental patterns.

The most common mistake: Tracking sick leave and attrition only as an aggregate, hospital-wide number, which masks exactly the department-level patterns that actually reveal a real problem.

SELF-ASSESSMENT QUESTIONS

1. Is staff sick leave data genuinely monitored and analysed, not simply recorded with no real review? — *Real, ongoing analysis, not data collected and left unexamined.*

Evidence: Sick leave analysis report

2. Are the genuine reasons staff leave the organisation actually captured, not assumed or left uninvestigated? — *Real, specific exit data, not departures treated as self-explanatory with no real inquiry.*

Evidence: Exit interview records

3. Is there a documented instance where this data genuinely informed a change supporting staff wellbeing or retention? — *A real, concrete example, not data gathered with no demonstrated influence on actual practice.*

Evidence: Specific change record linked to workforce data

COMMON REASONS FOR A PARTIAL ANSWER

- **Data is tracked hospital-wide but never broken down to the department level where patterns actually emerge.** — Aggregate data can mask exactly the localized pattern that signals a real problem.
- **Exit interviews happen inconsistently, with some leavers never genuinely interviewed at all.** — Consistent capture is necessary for the resulting data to be genuinely representative.
- **Patterns are identified but haven't yet translated into any real organisational change.**

IMPLEMENTATION PLAN

When	What
Week 1	Break down existing sick leave and attrition data to department level.

When	What
Week 2	Build a structured, consistent exit interview process.
Ongoing	Review data on a recurring schedule, specifically watching for departmental patterns.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Data analysis review	Reviews department-level sick leave and attrition analysis for genuine pattern review.
DOCUMENT	Change record review	Looks for a real, documented change explicitly linked to this workforce data.

SUPERVISOR TIPS

- **Ask whether any department has recently shown an unusual attrition or sick-leave pattern.** — A genuine, specific answer confirms the data is actually being reviewed, not just collected.
- **Check exit interview records for genuine, substantive reasons, not generic, vague entries.** — Specific, real reasons are the clearest evidence of a genuinely functioning process.

EVIDENCE BASE

International Council of Nurses. The Global Nursing Workforce and the COVID-19 Pandemic. Geneva: ICN; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

20.9

Equality, Diversity and Inclusion
Across the Workforce Are Genuinely Monitored

STANDARD

The organisation genuinely monitors and responds to real patterns of equity across recruitment, work allocation, scheduling, and promotion — not an assumption that fair

been raised.

In plain terms: The hospital actually looks at real patterns — who gets hired, which shifts people get, who gets promoted — not just assuming things are fair because nobody has formally complained.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Inequity in recruitment, scheduling, or promotion can genuinely persist for years without a single formal complaint — people often don’t report a pattern they can’t fully see themselves, or don’t trust reporting to change anything. Genuine, proactive monitoring of real workforce data is what actually surfaces a pattern that individual complaints alone would likely never reveal.

WHAT GOOD LOOKS LIKE

- Workforce data is genuinely monitored for patterns.
- A genuine pattern triggers a real response.
- A real instance shows monitoring informing a change.

COMMON FAILURE MODES

- No formal complaint has been raised, so the organisation genuinely assumes no issue exists, with no actual data ever reviewed.

WORKED EXAMPLE

IN PRACTICE

A hospital that had never reviewed its own scheduling data for patterns.

BEFORE

Shift scheduling was managed informally with no genuine review of whether certain staff consistently received less favourable assignments.

ACTION	A quarterly scheduling equity review was introduced, which identified and corrected a genuine, unintentional pattern.
AFTER	The Monitor reviewed the review documentation and the resulting correction. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a regular review of recruitment, scheduling, and promotion data for genuine patterns.

The most common mistake: Assuming fairness exists because no one has formally complained, with no actual data ever reviewed.

SELF-ASSESSMENT QUESTIONS

1. Is workforce data genuinely monitored for patterns of inequity? —

A real, documented monitoring process.

Evidence: Monitoring protocol

2. Where a genuine pattern is identified, is there a real, defined response? — *A genuine corrective process.*

Evidence: Response record

3. Is there a real, documented instance of this genuinely informing a change? — *A concrete, real example.*

Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- **Data exists but has genuinely never been reviewed specifically for equity patterns.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a quarterly equity review of recruitment, scheduling, and promotion data.

Method	What	Detail
DOCUMENT	Equity review record	Reviews the monitoring data and any resulting corrective action.

SUPERVISOR TIPS

- Ask to see the actual data behind the last equity review, not just a statement that one happened.

EVIDENCE BASE

World Health Organization. Gender Equity and Human Rights in the Health Workforce. Geneva: WHO; 2019.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

- ← Hospital Standards — all standards
- Self-assess against these criteria →
- ← Standard 19 — Digital Care & AI