

Hospital Standards

The complete ASF accreditation standard for hospital facilities. Every criterion is published in full — statement, classification, and the verification questions used by Monitors and supervisors. Free. No account required.

9 standards · 95 criteria · 73 non-negotiable · 22 core · 0 standard · Version 3.0



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How to read this page: Each standard groups related criteria. Each criterion has a classification — **Non-Negotiable** (all must be met; any single failure bars accreditation), **Core** ($\geq 85\%$ for accreditation, $\geq 70\%$ for certification), or **Standard** ($\geq 70\%$ for accreditation). The verification questions show what a Monitor checks. To test your facility against these criteria, use the free self-assessment tool.

STANDARD 1 · MANDATORY

Access & Arrival

1.1 Findable Before Arrival

Non-Negotiable

The facility's name, address, phone number, and mapped location are correct, current, and independently verifiable by anyone searching as a patient would.

1. Is the facility name, address, and phone number correct on your own website and any public listing? — Not the address on file with a regulator years ago — what a patient searching today would actually find.
2. Does the phone number listed actually connect to your facility when called? — Tested directly, not assumed because it was correct when first published.
3. If a map location is used, does the pin match the real entrance, not a nearby approximation? — A pin one block off sends ambulances to the wrong street in an emergency.

1.2 Hospital Grounds and Territory Entrance

Non-Negotiable

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

1. Is the boundary of the hospital's grounds — gate, fence line, or first entry point — clearly identifiable as the hospital's own territory? — Not the building itself — the point where a visitor first enters land the hospital is responsible for.
2. Is the approach from that entry point to the building itself safe, maintained, and clean? — Walkways, lighting, and general upkeep of the grounds themselves, not just the building interior.
3. Is there a single, clear route from the territory entrance to the main building, not multiple ambiguous paths? — A confusing arrival sequence undermines confidence before the visit has even properly begun.

1.3 Physical Access, or a Real Plan

Non-Negotiable

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

1. Is there at least one entrance a wheelchair user can use without staff physically lifting or carrying them? — A step, a narrow doorway, or a heavy unassisted door all count as a barrier.
2. If not, is there a specific, budgeted, dated plan to close the gap? — Not "we've discussed it" — a named structural change, a budget line, a date.
3. Has any real step already been taken toward that plan? — A quote obtained, materials ordered, or work scheduled — not just intention.

1.4 Emergency Entrance, Marked and Clear

Non-Negotiable

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

1. Is the emergency entrance signed clearly enough to be seen before arriving at the main door? — Visible from the approach a real ambulance or member of the public would take.
2. Is the route to it kept physically clear at all times? — Not just clear when checked — clear as a matter of routine.
3. Would two different staff members give the same directions to it if asked separately? — Inconsistent directions from staff usually means the signage itself is inadequate.

1.5 Wayfinding Without Staff Dependence

Core

Basic wayfinding allows someone with no prior knowledge of the building to locate reception, toilets, and the main clinical areas without stopping to ask for directions more than once.

1. Can a first-time visitor find reception using only your posted signage? — Not staff intercepting and redirecting.
2. Can they find the nearest toilet and one named clinical department the same way? — Test this with someone who has genuinely never been inside the building before.
3. Is signage consistent across every floor, or does it stop after the ground floor? — A common, specific failure.

STANDARD 2 · MANDATORY

Reception & Information

2.1 Patients Know Their Rights

Non-Negotiable

A patient rights charter exists, is visibly displayed, and patients can describe it in their own words — not a document filed away that nobody references.

1. Is a patient rights charter visibly displayed in areas patients actually pass through? — Not filed in an office — posted somewhere a patient waiting or arriving would see it.
2. Is the charter written in plain language, in the languages patients actually speak? — A legal document patients can't parse doesn't meet this, regardless of how thorough it is.
3. Can a patient asked directly describe at least one of their rights in their own words? — Not whether the charter exists — whether it reached them.

2.2 Pricing Is Disclosed Before Care Begins

Core

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

1. Is pricing information provided to patients before treatment begins, not only on the final invoice? — Cost disclosure after the fact doesn't allow informed decision-making.
2. Is pricing information given in a form the patient can keep and review, not only spoken once? — A verbal mention easily forgotten under stress is not the same as a document the patient can refer back to.

3. Can a patient describe roughly what they were told a procedure would cost, after being told? — Tests whether the disclosure actually registered, not just whether it technically happened.

2.3 Reception Desk Accessibility

Non-Negotiable

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

1. Is at least one reception or registration point at a height a wheelchair user can comfortably use? — Not the whole desk — at least one section genuinely usable at wheelchair height.
2. Can a wheelchair user communicate with the receptionist at eye level, not looking up at them? — Genuine eye-level interaction, not shouting up over a counter edge.
3. Is the lower section actually kept clear and usable, not blocked by files, equipment, or signage? — A lower desk section that exists but is permanently cluttered doesn't meet this in practice.

2.4 Health Information Is Genuinely Understandable, Not Just Provided

Core

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

1. Is health information routinely delivered in plain language, avoiding unexplained medical terminology? — Genuinely accessible language, not clinical terms used without explanation.
2. Is patient understanding actively verified, such as through teach-back, not assumed from a nod? — An active check, not passive delivery followed by an assumption it landed.
3. Are information materials available in the languages the patient population actually needs, not just the primary local language? — Matched to actual population need, not a single default assumption.

2.5 Waiting and Queue Time Is Actively Managed

Core

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

1. Is there a defined queue management system for registration, triage, and ambulatory waiting, not an informal first-come approach with no structure? — A specific, functioning system, not assumed to be self-evident from a waiting room and a door.
2. Is honest wait-time information visible or communicated to waiting patients? — Genuine, reasonably accurate information, not a vague reassurance or no information at all.
3. Is there a mechanism to notice if a waiting patient's condition changes or worsens while they wait? — Active monitoring of the waiting area, not only the queue order itself.

STANDARD 3 · MANDATORY

Environment & Shared Spaces

3.1 Water Supply Is Safe and Monitored

Non-Negotiable

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

1. Is water quality tested on a defined, regular schedule, with records kept? — "It's municipal water, it's fine" is an assumption, not a verified fact.
2. Is there a documented contingency plan for water supply interruption? — A plan written after the fact, during an actual interruption, is not a contingency plan.

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

3.2 Medical Equipment Is Maintained on Schedule

Non-Negotiable

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

1. Is there a documented maintenance schedule covering all clinical equipment? — Not equipment maintained "as needed" or reactively — a defined, proactive schedule.
2. Is faulty equipment actually removed from use, not kept in service while awaiting repair? — A tag or note isn't sufficient if the equipment remains physically accessible for use.
3. Is there a named person or role responsible for the maintenance programme? — Responsibility spread across nobody in particular usually means it happens inconsistently.

3.3 Shared Spaces Are Genuinely Clean

Core

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

1. Is there a documented cleaning schedule for shared spaces, with records kept? — Not a general statement that cleaning happens — a specific, dated schedule.
2. Is cleaning verified through more than a visual check, such as a defined inspection process? — Visual cleanliness and actual microbial cleanliness aren't the same thing.
3. Are high-touch surfaces specifically included in the schedule, not just visible floor and surface areas? — Door handles, rails, and switches are easy to overlook relative to more visible surfaces.

3.4 Facility Risks Are Tracked in One Integrated Register

Non-Negotiable

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

1. Do water safety, fire safety, and equipment maintenance data feed into one integrated risk register, not separate untracked lists? — A single place where facility leadership can see the whole risk picture, not scattered logs nobody reviews together.
2. Is the register reviewed on a defined schedule by facility leadership, not just maintained by individual department staff? — Review at a level that can act across domains, not only within one narrow area.
3. Does the register prioritise risks, not just list them? — A genuine risk management tool ranks what needs attention first, rather than treating every item as equally urgent.

3.5 An Environmental Sustainability Programme Is Genuinely Active

Core

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

1. Is there a specific, written sustainability programme covering energy, waste, and resource use? — A specific, documented programme, not a general statement of environmental values.
2. Is progress tracked against defined, measurable targets? — Real, trackable metrics, not an assumption that good intentions are sufficient.
3. Is there a named person or team responsible for the programme? — Specific ownership, not diffuse responsibility that belongs to nobody in particular.

3.6 Facility Signage Is Complete, Not Just Present at Reception

Non-Negotiable

Evacuation routes, emergency exits, restrooms, and procedure or department doors are clearly and consistently signed throughout the facility — not only the entrance and reception area covered under wayfinding, and not assumed adequately covered by evacuation drills alone.

1. Are evacuation routes and emergency exits clearly signed throughout the facility, not only near the main entrance? — Comprehensive coverage — deep corridors, upper floors, less-trafficked areas — not concentrated near reception.
2. Are restrooms and procedure or department doors clearly and consistently labelled? — Consistent labelling convention throughout, not signage that varies by department or era of installation.
3. Is signage periodically checked for damage, obstruction, or fading, not installed once and assumed permanent? — Signage degrades over time and needs the same ongoing attention as any other safety measure.

STANDARD 4 • MANDATORY

Care & Treatment

4.1 Consent Is Real, Not a Signature

Non-Negotiable

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

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

4.2 Staff Credentials Are Checked and Current

Non-Negotiable

Every clinical staff member's qualifications are verified and on file — checked directly with the issuing or licensing body, not taken on the applicant's word.

1. Is every clinical staff member's licence or qualification verified directly with the issuing body? — A photocopied certificate on file is not verification — contacting the issuer is.
2. Are credentials rechecked on renewal, not just at hiring? — A licence can lapse or be revoked after hiring without anyone noticing if it's never rechecked.
3. Is there a named person responsible for credential tracking, not an informal arrangement? — Responsibility spread across nobody in particular usually means it happens to nobody in particular.

4.3 New Staff Are Properly Onboarded

Non-Negotiable

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

1. Is there a documented induction checklist covering safety essentials before independent work? — Not a general welcome session — specific safety content, checked off item by item.
2. Does induction happen before independent work begins, not alongside it? — Learning safety essentials while already working unsupervised defeats the purpose.
3. Can a recently hired staff member describe what their induction actually covered? — A completed checklist with no real retention suggests a formality, not real training.

4.4 Staffing Actually Matches Patient Need

Non-Negotiable

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

1. Is staffing calculated against actual, current patient volume and acuity, not a fixed historical roster? — A roster set years ago and never revisited doesn't reflect today's real demand.
2. Is there a defined process for escalating when staffing falls short of documented need? — Recognising a shortfall is only useful if something happens as a result.
3. Can staff describe what happens when they're short-staffed, beyond "we manage"? — A vague answer usually means there's no real process, just accumulated coping.

4.5 Hand Hygiene Actually Happens

Non-Negotiable

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

1. Are hand hygiene stations physically present at the actual point of care, not just at ward entrances? — A station at the entrance to a ward doesn't help at the bedside where contact actually happens.
2. Is compliance measured through genuine, unannounced observation, not self-report? — Staff self-report on hand hygiene is notoriously unreliable — this needs real observation.
3. Is there a visible difference in supply availability between announced and unannounced checks? — Stations mysteriously well-stocked only during scheduled inspections is a specific, real failure pattern.

4.6 Protective Equipment Is Actually Available

Non-Negotiable

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

1. Is PPE physically accessible at the point of use, without requiring a key or a walk to another area? — Locked storage or distant supply points reduce actual use regardless of stock levels.
2. Is appropriate PPE available for the specific transmission risk of each area, not a generic kit everywhere? — A one-size-fits-all approach often means the wrong equipment is available where a specific risk exists.
3. Is stock monitored so that PPE doesn't run out mid-shift? — A stockout discovered mid-procedure is a preventable failure, not a supply chain inevitability.

4.7 Sharps and Waste Are Handled Safely

Non-Negotiable

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

1. Are sharps containers available immediately at the point of use, not requiring staff to walk with an exposed sharp? — Any distance travelled with an uncontained sharp is unnecessary risk.
2. Are containers replaced before they reach unsafe fill levels, not left to overflow? — An overfilled container is a direct, preventable injury risk.
3. Is clinical waste segregated correctly at the point of disposal, not sorted later? — Correct sorting after the fact requires someone to handle already-contaminated mixed waste.

4.8 Every Patient Gets a Real Assessment

Non-Negotiable

A structured clinical assessment happens on admission — a genuine evaluation using a defined process, not a chart entry completed to satisfy documentation requirements.

1. Is a structured assessment tool used on admission, not a free-text chart entry alone? — A structured tool ensures systematic coverage regardless of who is completing it or how busy they are.
2. Does the assessment happen within a defined timeframe of admission, not "eventually"? — An assessment completed a day late has already missed its window to catch early risk.
3. Is the assessment specific to the patient, or does it show signs of being copied from a previous entry? — Identical wording across different patients' assessments signals a formality, not a real evaluation.

4.9 There's an Actual Care Plan

Non-Negotiable

A documented, individualised care plan guides treatment — built from the patient's specific assessment, not a generic template applied regardless of their particular situation.

1. Is there a documented care plan specific to this patient's assessment findings, not a generic template? — A plan that could apply to any patient with a similar diagnosis, unchanged, suggests it wasn't individualised.
2. Does the care plan get updated as the patient's condition changes, not written once and left static? — A care plan that never changes despite documented changes in condition has stopped functioning as a plan.
3. Can a staff member taking over a shift find and understand the current care plan quickly? — A plan that's hard to locate or interpret at handover fails at the exact moment it matters most.

4.10 Medication Prescribing Is Safe

Non-Negotiable

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

1. Are prescriptions legible and complete, including dose, route, and frequency, without ambiguity? — An illegible or incomplete prescription forces the dispensing or administering staff to guess or assume.
2. Is there a defined second-check process for high-risk medications specifically? — General vigilance is not the same as a specific, mandatory second check for the medications most likely to cause serious harm.
3. Are prescribing errors, when caught, tracked and reviewed, not just quietly corrected? — A caught error that's never reviewed teaches the system nothing about why it happened.

4.11 The Surgical Safety Checklist Is Actually Used

Non-Negotiable

WHO's Surgical Safety Checklist is completed, out loud, as a genuine team pause for every procedure — not filed as paperwork after the fact.

1. Is the checklist completed out loud, as a team, before induction, before incision, and before the patient leaves theatre? — All three checkpoints, spoken, not just the pre-induction one done and the rest skipped.
2. Does every team member participate, not just the most senior person present? — A checklist read by one person to a silent room misses its purpose — catching what any team member might notice.
3. Is there evidence the checklist has actually changed a decision or caught an issue, not just been completed? — A checklist that's never once caught anything real over time is worth questioning, not just checking for completion.

4.12 Anaesthesia Is Delivered Safely

Non-Negotiable

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

1. Is continuous monitoring maintained throughout the entire procedure, not just at induction and emergence? — Gaps in monitoring during the middle of a long procedure are a real, documented risk pattern.
2. Is the monitoring equipment appropriate to the level of anaesthesia and actually functioning, not just present? — Equipment that's present but not properly calibrated or maintained provides false reassurance.
3. Is there a defined escalation protocol for anaesthesia-related complications? — A protocol for the routine case is not the same as a protocol for when something goes wrong.

4.13 Surgical Site Infection Is Actively Prevented

Non-Negotiable

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

1. Is a specific, defined SSI prevention bundle followed for every procedure, not general practice? — "We're careful about infection" is not the same as a specific, checkable bundle of practices.
2. Is the facility's own SSI rate actually measured and tracked? — Improvement isn't possible against a rate nobody is measuring.

3. Is bundle compliance checked per procedure, not assumed from general training? — General training doesn't guarantee the bundle was actually followed on any specific occasion.

4.14 The Lab Has Quality Control

Non-Negotiable

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

1. Does internal quality control run before every batch of results is released, without exception? — "Usually" or "when there's time" is not the same as a genuine non-negotiable step.
2. Is there a defined process for what happens when quality control fails? — A QC failure needs a clear, followed response, not ad hoc decision-making in the moment.
3. Are QC records retained and reviewable, not just checked and discarded? — Retained records allow pattern detection over time that a single check can't reveal.

4.15 Critical Lab Values Reach the Doctor Fast

Non-Negotiable

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

1. Is there a distinct, faster pathway for critical values, separate from routine result reporting? — If critical values go into the same queue as everything else, speed depends on luck, not design.
2. Is receipt of a critical value confirmed by the receiving clinician, not just assumed from transmission? — A result sent is not the same as a result received and acknowledged by someone who can act on it.
3. Is there a defined escalation if the first attempt to reach a clinician fails? — A single failed contact attempt shouldn't be where the process quietly stops.

4.16 Specimens Are Correctly Identified

Non-Negotiable

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

1. Are two identifiers checked before specimen collection, not just one? — A single identifier — a bed number, for instance — is not sufficient on its own.
2. Is identity checked again before testing, independently of the collection-time check? — A single check at collection doesn't catch an error introduced afterward, in transit or labelling.
3. Can staff describe what happens when identifiers don't match? — A clear stop-and-resolve process, not proceeding anyway under time pressure, is essential.

4.17 Medication Storage Is Secure and Correct

Non-Negotiable

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

1. Are temperature-sensitive medications stored within their required range, monitored and logged? — A fridge that's "probably fine" is not the same as one with a monitored, logged temperature record.
2. Is access to medication storage restricted to authorised staff specifically, not generally available? — General staff access, even with good intentions, undermines accountability and control.
3. Are storage conditions checked routinely, not only when something seems wrong? — Routine checking catches drift before it becomes a problem; reactive checking catches it after.

4.18 High-Alert Medications Get Extra Safeguards

Non-Negotiable

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

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

2. Is the double-check performed by a genuinely independent second person, not the same clinician? — Self-verification doesn't provide the independent perspective the safeguard is designed to add.
3. Is the double-check documented, not just assumed to have happened? — An undocumented check leaves no way to verify it actually occurred as intended.

4.19 Medication Reconciliation Actually Happens

Non-Negotiable

Admission and discharge medication lists are compared and discrepancies resolved by a trained, designated person — a genuine, documented reconciliation process, not an assumption that the lists already match, and not dependent on a clinical pharmacist role this facility may not have.

1. Is a formal reconciliation process completed at both admission and discharge, comparing medication lists directly? — Reconciliation only at one transition point, not both, leaves a real gap.
2. Are discrepancies found during reconciliation actually resolved and documented, not just noted? — Identifying a discrepancy without resolving it provides no real safety benefit.
3. Does the process include the patient's own account of what they actually take, not only prior records? — Prior records can be outdated or incomplete — the patient's own current account is a necessary cross-check.

4.20 Patient Identified Correctly at Every Point of Contact

Non-Negotiable

Every patient is verified using at least two identifiers before any medication, procedure, blood product, or specimen collection — not only for laboratory work, but at every point contact could go wrong.

1. Are two identifiers checked before every medication administration, not only during specimen collection? — The same two-identifier discipline applied to lab work needs to extend to medication rounds.
2. Is a room or bed number ever used as a patient identifier? — Room and bed numbers change and are never acceptable as an identifier on their own.
3. Is patient identification checked before blood products and before procedures, independently each time? — Each new point of contact needs its own check, not reliance on identification done earlier in the encounter.

4.21 Falls Risk Assessed and Actively Prevented

Non-Negotiable

Every patient is assessed for fall risk on admission using a structured tool, with prevention measures implemented for anyone identified at risk, and every fall tracked as a safety indicator.

1. Is every patient assessed for fall risk on admission using a structured, validated tool? — Not clinical impression alone — a defined scoring tool such as the Morse Fall Scale or an equivalent.
2. Are specific prevention measures implemented for patients identified as high risk? — A completed assessment that doesn't change anything about care provides no real protection.
3. Are falls tracked as a safety indicator, with each fall reviewed? — Tracking without review misses the chance to learn from each incident.

4.22 Look-Alike, Sound-Alike Medications Are Specifically Managed

Core

Medications with names or packaging that could be confused with another are identified on a specific list and managed with distinct safeguards — separated storage, distinct labelling, or an independent check — not treated the same as any other medication.

1. Does a specific, named list of look-alike, sound-alike medications exist for this facility's own formulary? — Generic awareness of the concept is not the same as a specific list for what this facility actually stocks.
2. Are LASA medications stored separately or distinctly labelled to prevent mix-up? — Physical or visual separation, not reliance on staff memory alone.
3. Is there a specific check step for LASA medications distinct from general dispensing practice? — An additional safeguard specific to this risk, not just standard dispensing care.

4.23 Restraint and Seclusion Use Is Governed and Minimised**Core**

Physical or chemical restraint and seclusion are used only under a defined protocol, as a last resort, time-limited, monitored, and documented — never as a routine or convenience practice.

1. Is there a written protocol governing when restraint or seclusion may be used, as a last resort only? — A specific, documented threshold, not a general judgement call left to individual staff.
2. Is every use time-limited, monitored, and documented, with a defined review point? — Open-ended or unmonitored use is not acceptable under any protocol.
3. Is restraint or seclusion use reviewed to check it isn't becoming routine for particular patients or situations? — Pattern review catches drift from last-resort toward habitual use.

4.24 Nutrition and Therapeutic Diet Needs Are Actively Managed**Core**

Patients are screened for nutritional risk, therapeutic diets are correctly identified and delivered, and food handling meets basic safety standards — nutrition treated as part of clinical care, not a hospitality afterthought.

1. Is every patient screened for nutritional risk on admission? — A specific screening step, not an assumption that nutrition will be addressed informally if it becomes relevant.
2. Are therapeutic diets correctly identified, prescribed, and verified as delivered to the right patient? — A diet order that doesn't reliably reach the correct patient provides no real benefit.
3. Does food handling meet basic safety standards, verified directly, not assumed? — Kitchen and food service hygiene checked directly, the same discipline applied to clinical infection control.

4.25 Deteriorating Patients Are Caught Before the Crisis, Not After**Non-Negotiable**

A structured early warning score is calculated from routine vital signs, tracked over time, and triggers a defined escalation response when it crosses a threshold — not left to individual clinical impression alone to notice a patient is declining.

1. Is a structured early warning score calculated from routine vital signs, not just individual readings checked in isolation? — A composite score tracking trend, not six separate numbers each compared to a normal range independently.
2. Is there a defined escalation response triggered when the score crosses a specific threshold? — A specific, named response — not "someone will probably notice and do something."
3. Is the score recalculated on a defined schedule, not only when a nurse happens to have time? — A schedule that holds even during busy shifts is what actually catches deterioration in time.

4.26 Sepsis Is Recognised and Treated Within the Hour**Non-Negotiable**

Staff are trained to recognise sepsis using a standardised screening approach, and a defined care bundle — including prompt antibiotics and fluid resuscitation — is initiated without delay once sepsis is suspected, not after a diagnosis is fully confirmed.

1. Is there a standardised screening approach staff use to identify possible sepsis, not informal clinical suspicion alone? — A specific, structured screening tool, not left to individual recognition varying by experience.
2. Does a defined care bundle begin immediately on suspicion, not after full diagnostic confirmation? — Suspicion triggers action; waiting for certainty costs the time that matters most.
3. Is time from suspicion to first antibiotic dose tracked as a specific, monitored metric? — An untracked interval cannot be improved, and clinicians won't know if delays are happening.

4.27 Pressure Injury Risk Is Assessed and Actively Prevented**Core**

Every patient is assessed for pressure injury risk on admission and periodically thereafter, with a specific, documented prevention plan for at-risk patients — repositioning schedules, appropriate surfaces — not addressed only after an injury has already developed.

1. Is every patient assessed for pressure injury risk on admission using a structured tool? — A validated risk assessment tool, not visual inspection alone.
2. Is risk reassessed periodically during a stay, not only at the point of admission? — Risk can change significantly as a patient's mobility or condition changes during their stay.
3. Does a documented, specific prevention plan exist for patients identified as at-risk? — Specific interventions — repositioning schedule, surface type — not a general awareness the patient is at risk.

4.28 VTE Risk Is Assessed Before Every Admission and Procedure

Core

Every patient is assessed for venous thromboembolism risk at admission and before surgical procedures, with appropriate prophylaxis — pharmacological or mechanical — genuinely prescribed and administered for at-risk patients, not left as a general awareness that blood clots are a possible complication.

1. Is every patient assessed for VTE risk at admission using a structured tool? — A specific, structured assessment, not informal judgement about which patients seem higher risk.
2. Is risk reassessed before surgical procedures specifically, not only at general admission? — Surgery itself changes VTE risk, and pre-procedure reassessment catches that shift.
3. Is appropriate prophylaxis actually prescribed and administered for patients identified as at-risk? — Identification without follow-through provides no real protection.

4.29 Blood and Blood Products Are Verified Before Every Transfusion

Non-Negotiable

Blood and blood products are matched to the correct patient through an independent two-person verification at the bedside immediately before transfusion, with the reaction monitored throughout — not a single check at collection assumed to hold true all the way to administration.

1. Is there an independent two-person verification of blood product and patient identity immediately before transfusion, at the bedside? — Two people, independently, at the actual point of administration — not a single check earlier in the process.
2. Is the patient monitored for a reaction during and immediately after transfusion, on a defined schedule? — A specific monitoring schedule, not "someone will notice if something goes wrong."
3. Is there a defined, immediate response protocol for a suspected transfusion reaction? — A specific, known process — not improvisation in the moment.

4.30 Handoffs Use a Structured, Verbal Process — Not Just a Written Note

Non-Negotiable

Clinical handoffs between shifts or care teams follow a structured, standardised format delivered verbally with an opportunity to ask questions — not a written note alone that the receiving clinician reads without any live exchange.

1. Do handoffs follow a structured, standardised format, not an unstructured verbal or written summary? — A defined structure — covering the same essential elements every time, not left to individual habit.
2. Is the handoff delivered live and verbally, with an opportunity for the receiving clinician to ask questions? — Live exchange, not a written note read in isolation with no chance to clarify.
3. Is the handoff process consistent across shift changes and between departments, not only within one team's habit? — Consistency matters most exactly at the boundaries where information is most likely to be lost.

4.31 Opioid Prescribing Is Deliberately Stewarded

Core

Opioid prescribing follows a defined stewardship approach — appropriate dose and duration, genuine consideration of non-opioid alternatives, and monitoring for signs of diversion or misuse — led by a trained, designated person or a physician champion where no dedicated pharmacy function exists, not treated identically to any other medication once high-alert safeguards are satisfied.

1. Is there a defined stewardship approach for opioid prescribing, distinct from general high-alert medication management? — Specific to opioids — dose, duration, alternatives — not folded generically into broader medication safety.
2. Are non-opioid alternatives genuinely considered and documented before opioid prescribing, not just theoretically available? — Evidence of actual consideration, not an assumption that alternatives were weighed.
3. Is there monitoring for signs of diversion or misuse, not just appropriate initial prescribing? — Stewardship extends beyond the prescribing moment into ongoing awareness.

4.32 Pain Is Formally Assessed and Reassessed, Not Just Asked About Once

Core

Every patient's pain is assessed using a structured tool on admission and reassessed at defined intervals, particularly after any intervention intended to address it — not asked about once informally and left unvisited.

1. Is pain assessed using a structured tool on admission, not an informal, unstructured question? — A specific, structured scale appropriate to the patient, not a general "how are you feeling" check.
2. Is pain reassessed at defined intervals, particularly after any intervention intended to address it? — Reassessment specifically tied to interventions, not just a general periodic check.
3. Are reassessment results actually used to adjust the care plan, not just recorded and left unactioned? — A reassessment that doesn't influence care provides no real benefit over not reassessing at all.

4.33 Dignity, Respect, and Non-Discrimination Are Practised, Not Just Stated

Non-Negotiable

Every patient is treated with dignity and respect regardless of background, and care decisions are demonstrably free of discrimination based on race, religion, gender, disability, sexual orientation, or any other protected characteristic — verified through observation and patient experience, not assumed from a written policy.

1. Is there a written non-discrimination policy covering care decisions, not only administrative or employment matters? — Specifically covering clinical care and treatment decisions, not just a general workplace policy.
2. Can staff describe specific ways they ensure equitable treatment across different patient backgrounds? — Concrete, specific practices, not a general assurance that discrimination doesn't happen here.
3. Is there a mechanism for a patient to report perceived discriminatory treatment, distinct from a general complaint process? — A pathway that specifically names and takes discrimination concerns seriously, not folded anonymously into general feedback.

4.34 Vulnerable Patients Get Real, Specific Protections

Non-Negotiable

Patients who are elderly, cognitively impaired, or otherwise vulnerable to reduced capacity for self-advocacy receive specific, documented additional protections — not the same general care approach applied to every patient regardless of their actual ability to protect their own interests.

1. Is there a process to identify patients with reduced capacity for self-advocacy, not left to informal staff judgement alone? — A specific, structured identification process, not assumed to be obvious.
2. Do identified vulnerable patients receive specific, documented additional protections? — Concrete, named protections — not the same general care approach applied to everyone.
3. Is there a designated advocate or process ensuring a vulnerable patient's interests are actively represented in care decisions? — Active representation, not an assumption that standard processes adequately protect everyone equally.

4.35 Advance Directives Are Sought, Documented, and Actually Followed

Core

Patients are asked about existing advance directives and offered support to create one where appropriate, with any documented directive genuinely accessible to the care team and followed — not asked once as a formality with no real mechanism ensuring it influences actual care decisions.

1. Are patients asked about existing advance directives as part of standard admission practice? — A routine, standard question, not asked inconsistently or only when a situation prompts it.
2. Is a documented advance directive genuinely accessible to the care team at the point of an actual decision? — Findable in the moment it matters, not filed somewhere nobody checks during an emergency.
3. Is there evidence that documented directives actually influence care decisions when relevant? — Genuine adherence, not just documentation that exists but goes unconsulted.

4.36 The Facility Tracks Its Own Infection Rate Over Time

Core

The facility measures and trends its own healthcare-associated infection rate as a standing indicator, reviewed regularly — not only following individual prevention bundles like surgical site infection practice, without ever stepping back to see whether the overall rate is actually improving.

1. Does the facility measure its own healthcare-associated infection rate, not only comply with individual prevention practices? — A real, tracked number specific to this facility, not an assumption that following the bundles is sufficient on its own.
2. Is the rate trended over time and reviewed on a regular schedule, not calculated once and left unexamined? — A single measurement doesn't show a trend; regular review is what reveals whether prevention practice is actually working.
3. Does the facility know whether its rate is improving, worsening, or unchanged, and can it say why? — Genuine engagement with what the data shows, not data collected and filed without interpretation.

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

Non-Negotiable

Where an electronic system is used for medication safety checks — drug interactions, allergy alerts, duplicate therapy — its actual function is verified and audited, not assumed from its presence, and where records are split between paper and electronic, one is clearly designated as the record staff check first, so the two can never silently disagree about what a patient is actually taking.

1. If your electronic system claims to check for drug interactions, allergies, or duplicate therapy, has this actually been tested and confirmed to work — not assumed from the system's marketing or original configuration? — A specific test — entering a known interacting pair and confirming an alert fires — not an assumption the feature works because it was purchased.
2. If safety checks are not confirmed working, or don't exist, is there a specific manual backup step staff genuinely use instead? — A defined paper checklist or verbal double-check, not an informal hope that staff will individually remember to be careful.
3. Where records are split between paper and electronic — common during power instability — is one specific version designated as what staff check first, avoiding the two silently disagreeing? — A named, consistent rule, not left to individual staff judgement about which version to trust in the moment.

STANDARD 5 · MANDATORY

Safety & Emergency Preparedness

5.1 Triage Actually Sorts Patients by Urgency

Non-Negotiable

A structured triage system using a validated, internationally recognised urgency scale — such as the Manchester Triage System, the Canadian Triage and Acuity Scale, or an equivalent validated tool —

prioritises patients by clinical urgency, used consistently for every arriving patient, not applied selectively based on how busy the department is.

1. Is a validated, internationally recognised triage scale used, not an informal or home-grown urgency judgement? — A named, validated tool — Manchester Triage System or equivalent — not individual staff discretion alone.
2. Does every triage nurse or staff member use the same scale consistently, not a personal variation of it? — Consistency across staff is what makes the scale meaningful as a system, not just a suggestion.
3. Is the assigned urgency category documented for every patient, with the maximum wait time it implies? — A category without a documented, implied wait time doesn't translate into an actual commitment to the patient.

5.2 Resuscitation Equipment Is Ready Right Now

Non-Negotiable

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

1. Is resuscitation equipment checked every shift, with a documented record? — Not checked "regularly" — checked every single shift, verifiably.
2. Is all equipment found fully stocked and functional at each check, with gaps immediately addressed? — A check that finds gaps but doesn't trigger immediate resupply provides only partial protection.
3. Are all relevant staff current on life support certification, not overdue? — A lapsed certification discovered only during an emergency is a preventable failure.

5.3 There's a Real Disaster Response Plan

Non-Negotiable

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

1. Does a documented mass casualty and disaster response plan exist? — Specific to mass casualty and disaster scenarios, not a general emergency policy.
2. Has the plan actually been practised through a drill, not just written and filed? — An unrehearsed plan's real-world gaps are unknown until an actual disaster reveals them.
3. Were lessons from the drill documented and used to update the plan? — A drill that doesn't feed back into plan improvement misses much of its value.

5.4 Fire Safety Is Real, Not Theoretical

Non-Negotiable

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

1. Is fire safety equipment tested on a defined schedule, with records kept? — Extinguishers, alarms, and sprinkler systems specifically, not a general assumption of functionality.
2. Has an evacuation drill actually been run, with real staff and patient-area participation? — A tabletop discussion of the evacuation plan is not the same as a physical drill.
3. Are evacuation routes kept genuinely clear, not obstructed in practice? — A route that's clear on paper but blocked by stored equipment fails when it matters.

5.5 Workplace Violence Is Prevented, Not Just Responded To

Non-Negotiable

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

1. Is there a written workplace violence policy covering violence from patients and visitors, and separately, staff-on-staff violence? — Both categories explicitly, not just one assumed to cover the other.
2. Was the policy developed in consultation with staff, not written and issued without their input? — Genuine consultation, since staff experience is what makes a prevention policy actually relevant.

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

5.6 Internal Emergency Alerts Are Clear, Consistent, and Trained

Non-Negotiable

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

1. Does the facility have a clearly documented internal emergency alert system, whether colour-coded or plain-language? — A specific, written system — not an assumption that staff will understand codes from general experience elsewhere.
2. Are all staff, including new hires and temporary or agency staff, trained on this specific facility's system? — Facility-specific training, not reliance on what a code meant at a previous workplace.
3. Can staff correctly state what happens for each alert type used at this facility, not just recognise that an alert occurred? — Understanding the required response, not just recognising that something is happening.

STANDARD 6 · MANDATORY

Aftercare & Follow-up

6.1 Every Discharged Patient Gets a Real Aftercare Plan

Non-Negotiable

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

1. Does every discharged patient receive a documented aftercare plan specific to their situation? — Not a generic discharge sheet — content specific to this patient's condition and treatment.
2. Can a recently discharged patient explain their own aftercare plan in their own words? — Tests whether the plan was actually understood, not just handed over.
3. Does the plan cover medication, warning signs, and who to contact if something goes wrong? — A plan missing any of these three leaves a genuine gap in what the patient needs to manage safely at home.

6.2 A Real Mechanism Checks on the Patient After They Leave

Non-Negotiable

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

1. Is there a defined mechanism to actively check on patients after discharge, not just availability on request? — The facility initiating contact, not merely being reachable if the patient calls first.
2. Does the mechanism apply consistently, not only for cases staff happen to remember? — A follow-up system that depends on individual staff memory is not a reliable system.
3. Is there a defined escalation if a follow-up contact reveals a concerning symptom or complication? — Detecting a problem during follow-up is only useful if something happens as a result.

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

Non-Negotiable

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

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

2. Is there evidence complaints are actually read and result in a response, not just filed? — A collected complaint with no follow-through provides no real value to the patient or the facility.
3. Have any complaints led to a documented change in practice? — A complaint system that has never once led to a change is worth questioning, not just checking for the existence of a form.

STANDARD 7 · MANDATORY

Governance & Management

7.1 The Board Is Real and Accountable

Non-Negotiable

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

1. Is there a documented governing body with named members and defined terms of office? — A charter or bylaws naming members and terms, not an informal ownership arrangement.
2. Does the governing body meet on a fixed schedule with minutes retained? — Minutes showing attendance, decisions, and follow-up actions, not just that a meeting occurred.
3. Does the board formally review quality and safety performance at each meeting, not only financial performance? — A standing quality agenda item with real data discussed, not an afterthought.

7.2 There Is a Written Strategic Plan

Non-Negotiable

A documented plan states the hospital's mission and genuinely guides resourcing decisions — not a one-page mission poster disconnected from how money and staff time actually get allocated.

1. Is there a written strategic plan covering at least a multi-year horizon? — Not an annual budget alone — a plan with genuine forward horizon.
2. Does the plan include a clear mission statement describing who the hospital serves and how? — Specific enough to guide real decisions, not generic enough to apply to any hospital anywhere.
3. Can a resourcing decision from the last year be traced back to something in the plan? — Tests whether the plan actually influences decisions, not just whether it exists.

7.3 Policy Actually Gets Followed

Non-Negotiable

A policy framework exists and staff can describe how it's genuinely applied in practice, not merely confirm that policies are filed and technically available.

1. Can staff describe how a specific, named policy is actually applied in their daily work? — Not whether they know a policy exists — whether they can describe applying it.
2. Is there a mechanism to check policy adherence, not just policy existence? — A policy audit or spot-check process, distinct from simply confirming documents are filed.
3. When a policy-practice gap is found, is there a defined response, not just noting the discrepancy? — Identifying a gap without addressing it provides limited real value.

7.4 Patient Information Stays Private

Non-Negotiable

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

1. Are screens and monitors positioned so patient information isn't visible to passersby or other patients? — Physical positioning, checked directly, not assumed from a policy statement.
2. Are clinical conversations conducted where they can't be overheard by other patients or visitors? — Curtains, closed doors, or private spaces genuinely used, not just available.
3. Do staff understand and apply confidentiality practices consistently, not only when reminded? — Tests whether privacy protection is habitual, not situational.

7.5 Medical Records Are Complete

Non-Negotiable

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

1. Is there a defined list of mandatory record elements for each type of encounter? — A specific, checkable list, not a general expectation of thoroughness.
2. Are records regularly audited for completeness against that list? — Genuine audit, not assumption of completeness because a template was used.
3. Are gaps found during audits actually addressed, not just noted? — Identifying an incomplete record without correcting it leaves the underlying risk unresolved.

7.6 Patient Data Is Kept Secure

Non-Negotiable

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

1. Are access controls in place restricting patient data access to staff who need it for their role? — Role-based restriction, not general access available to any staff member.
2. Is there a documented breach response plan, specific and actionable? — Not a general statement of concern — a named process for what happens if a breach occurs.
3. Have access controls and the breach plan been reviewed or tested recently? — An untested plan or unreviewed control list may not reflect current reality.

7.7 Records Are Kept Exactly as Long as Required

Non-Negotiable

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

1. Does a written retention policy exist, specifying how long different record types are kept? — Specific durations by record type, not a vague general statement.
2. Is the retention period aligned with the actual legal requirement in this jurisdiction? — Verified against the real legal requirement, not assumed or copied from another context.
3. Is disposal of records past their retention period conducted securely and documented? — Disposal that protects confidentiality even as the record is destroyed.

7.8 Incidents Are Actually Reported

Non-Negotiable

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

1. Is the incident reporting system genuinely accessible to all staff, not just management? — Accessible in practice, at the point of work, not buried in an administrative system.
2. Does actual reporting volume suggest genuine use, not just technical availability? — A system that exists but receives almost no reports over time suggests a use problem, not a safety-perfect facility.
3. Do staff believe they can report without fear of punitive consequence? — Genuine psychological safety, not just a stated non-punitive policy.

7.9 Serious Incidents Get Properly Investigated

Non-Negotiable

Root cause analysis is genuinely used for serious incidents, with a resulting, tracked action plan — not a brief note explaining what happened without examining why it happened.

1. Is a structured root cause analysis method used for serious incidents, not just a brief incident note? — A defined methodology examining systemic factors, not a one-paragraph summary.
2. Does the RCA result in a specific, tracked action plan? — Findings without a resulting plan don't translate into prevention.

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

7.10 Safety Culture Is Actually Measured

Non-Negotiable

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

1. Is a validated safety culture survey conducted, not an informal or ad hoc check? — A recognised, validated tool, not an internally improvised questionnaire.
2. Is the survey conducted regularly, on a defined schedule? — A single historical survey doesn't reflect current culture.
3. Are survey results reviewed and acted on, with visible follow-up? — Measurement without action provides no real improvement.

7.11 Patient Experience Is Measured Continuously, Not Only After Discharge

Core

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

1. Is patient experience measured through structured feedback during the stay, not only after discharge? — Real-time or near-real-time feedback, distinct from the post-discharge complaint channel.
2. Is feedback collected broadly, not only from patients who happen to volunteer it? — A systematic approach, not reliance on the small subset of patients naturally inclined to give feedback.
3. Is collected feedback actually reviewed and used to inform real improvements? — Genuine responsiveness, not data collected and left unexamined.

7.12 A Real Ethics Consultation Process Exists

Core

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

1. Is there a real, accessible ethics consultation process — committee, named resource, or external arrangement? — An actual, usable resource, not a theoretical statement that ethical principles matter.
2. Do staff know how to access it, not just that it exists somewhere in policy? — Practical, known accessibility — staff can describe how they'd actually use it.
3. Has the process actually been used for a real case, or does it exist only theoretically? — Genuine use is the real test of whether this is a functioning resource or a document nobody has needed to open.

7.13 Patients and Families Have a Real Voice in Governance

Core

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

1. Does at least one patient or family representative have a genuine, structured role in quality review or governance discussions? — An actual seat or defined role, not indirect input filtered through staff-collected feedback alone.
2. Is this representative genuinely included in discussion, not present only as an observer? — Real participation, not token attendance without a voice in the discussion.
3. Can the facility point to a specific instance where patient or family input shaped a real decision? — Concrete evidence of influence, not just presence.

STANDARD 8

Medical Tourism

8.1 Pricing Transparency for International Patients

Non-Negotiable

International patients receive a complete, written, all-inclusive cost estimate before travel is booked — covering the procedure, hospital stay, and commonly needed extras — not a partial quote that grows once the patient has already committed to travelling.

1. Is a complete, written cost estimate provided before the patient books travel? — Before travel is booked, not after arrival — the point where the patient still has a real choice.
2. Does the estimate cover commonly needed extras, not just the base procedure? — Anaesthesia, extended stay, common complications — the items that turn a quoted price into a real surprise.
3. Can a recent international patient confirm the final cost matched the estimate, or that any difference was clearly explained in advance? — Tests whether the estimate was honest, not just early.

8.2 Remote Records Transfer to Home-Country Physician

Non-Negotiable

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

1. Is a complete treatment record transferred to the patient's home-country physician, not just given to the patient to pass along? — Direct transfer, not relying on the patient to correctly deliver and explain their own paperwork.
2. Is the record provided in a language and format the home physician can genuinely use? — Translated where needed, not just exported in the treating facility's own internal format.
3. Is transfer confirmed as received, not just sent? — A record sent into an unconfirmed inbox provides no more protection than no record at all.

8.3 Language Access for Foreign Patients

Non-Negotiable

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

1. Is a genuinely competent interpreter — professional or trained — used for consent and major treatment discussions? — Not whichever staff member happens to speak some of the language informally.
2. Are discharge instructions specifically covered through proper language access, not simplified or skipped due to language barriers? — Discharge is exactly the point where miscommunication causes the most post-return harm.
3. Can the facility name which languages it can genuinely support, and what happens when a patient's language isn't covered? — A specific, honest answer, not a general assurance language is never a problem.

8.4 Travel, Accommodation, and Logistics Coordination

Core

The facility provides or coordinates genuine support for travel and accommodation logistics around the procedure — not leaving an international patient, often recovering from treatment, to navigate this entirely alone in an unfamiliar country.

1. Does the facility provide or coordinate genuine support for accommodation appropriate to the patient's recovery needs? — Matched to actual recovery requirements, not a generic hotel list handed over without guidance.
2. Is local transport between accommodation and the facility genuinely arranged or clearly explained? — Not assumed the patient will figure out local transport independently while recovering.
3. Is there a named point of contact for logistics questions during the patient's stay? — A specific person or service the patient can actually reach, not a general inquiry line.

8.5 Post-Return Complication Tracking

Non-Negotiable

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

1. Is there a specific, active mechanism to learn about complications discovered after a patient returns home? — Beyond a generic satisfaction call — a real channel for the patient's home physician or the patient themselves to report a problem.
2. Does the facility request feedback from the patient's home physician, not only the patient? — A home physician is often better positioned to identify a genuine complication than the patient describing symptoms informally.
3. Are post-return complications, when identified, tracked and reviewed as a quality indicator? — Tracking without review misses the chance to improve future international patient care.

8.6 Visa and Embassy Support Documentation

Core

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

1. Does the facility know the specific visa and documentation requirements for the countries its patients most commonly travel from? — Specific, current knowledge, not general awareness that visas are sometimes needed.
2. Are required documents provided correctly and promptly, avoiding delays that could affect a patient's ability to travel in time? — Timeliness matters especially for clinically urgent cases.
3. Is there a named person responsible for visa and embassy documentation support? — Specific ownership, not a task that falls to whoever happens to have time.

8.7 International Patient Complaint and Redress Process

Non-Negotiable

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

1. Can an international patient submit a complaint from their home country, in a language they can use? — Genuinely reachable remotely, in a language the patient can actually communicate in.
2. Is there evidence international patient complaints are actually reviewed and result in a response? — Not just receipt acknowledgment — a substantive response addressing the actual concern.
3. Does the process account for the practical difficulty of an international patient providing follow-up information or documentation from abroad? — A process designed only for local patients can create unreasonable barriers for someone no longer in the country.

8.8 Facilitator and Agent Verification

Non-Negotiable

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

1. Does the facility maintain a list of verified facilitators and agents it actually works with? — A specific, maintained list, not an open, unmonitored referral relationship with anyone claiming to be an agent.
2. Is there a defined standard of conduct facilitators must meet, covering accurate representation of costs, risks, and outcomes? — A specific, communicated standard, not an assumption that facilitators will represent things accurately on their own.
3. Is there a process for addressing a facilitator found to have misrepresented information to a patient? — A defined consequence, not an unaddressed pattern of misrepresentation.

8.9 Travel-Associated Infection Risk Protocol

Non-Negotiable

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

1. Is there a specific screening protocol for travel-associated infection risk applied to international patients? — Beyond standard admission screening — specific attention to recent travel and country-of-origin risk factors.
2. Does screening account for country-specific resistance patterns where relevant? — Generic screening can miss risks specific to certain regions or recent healthcare exposure abroad.
3. Are appropriate precautions applied based on screening results, not just documented and set aside? — Findings that don't change practice provide no real protection.

8.10 Post-Procedure Travel Timing and Venous Thromboembolism Risk

Non-Negotiable

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

1. Does every international patient receive a specific, documented discussion of safe travel timing for their specific procedure? — A specific, procedure-appropriate discussion, not a generic travel disclaimer.
2. Is the discussion specific to blood clot risk from combining this procedure with air travel, not general recovery advice? — The specific risk named directly, not folded into general aftercare instructions.
3. Can the patient explain back the recommended minimum time before flying, specific to their own procedure? — Tests genuine understanding specific to this patient, not general awareness that travel timing matters.

STANDARD 9

Refugee & Migrant Health

9.1 People-Centred Care Adapted to Migration and Displacement Experience

Non-Negotiable

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

1. Are staff trained to adapt their practice based on a patient's migration and displacement experience, not deliver identical care regardless of history? — Genuine adaptation, not a generic cultural-awareness statement.
2. Is trauma-informed practice applied, including not routinely asking for detailed trauma history at initial visits? — WHO specifically advises against probing for detailed trauma history early in care.
3. Does the facility support continuity of care regardless of a patient's legal status? — Access not conditioned on documentation the patient may not have or be able to safely provide.

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

Non-Negotiable

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

1. Is understanding actively checked using a teach-back approach, for both the immediate care plan and how to navigate the system, not assumed from a nod? — Asking the patient to explain both back in their

own words, not just asking "do you understand?"

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

3. Is information communicated in plain language, avoiding medical jargon, particularly when working through an interpreter? — Complex terminology strains interpretation and comprehension together.

9.3 Language and Communication Aids — Interpreters and Cultural Mediators

Non-Negotiable

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

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

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

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

9.4 Collaborative Practice Across Health and Social Services

Core

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

1. Does the facility have working relationships with relevant legal, housing, or social support services for referral? — Actual working relationships, not just awareness that such services theoretically exist.

2. Does handover of care to another provider include migration- and displacement-related context, not just clinical facts? — Cultural, language, and migration context specifically included in handover.

3. Are staff from refugee or migrant backgrounds, where present, genuinely utilised for their relevant skills and insight? — Recognising this as a specific asset, not incidental to their role.

9.5 Surge Capacity for Migration-Related Demand

Non-Negotiable

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

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

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

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

9.6 Evidence-Informed Care for Refugee and Migrant Populations

Core

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

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

2. Can staff describe how refugee and migrant health needs may differ from the general population for conditions they commonly treat? — Genuine awareness of specific, relevant differences, not a general acknowledgment that differences might exist.
3. Is there a process for identifying and responding to gaps in evidence specific to this population? — Recognising uncertainty is itself part of good practice here, not something to paper over.

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

Non-Negotiable

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

1. Does the facility have a structured process for staff reflective practice regarding bias and cultural awareness? — A defined process, not an assumption that staff will naturally self-reflect adequately.
2. Does the facility provide genuine, accessible psychological support and a structured space to debrief difficult cases? — Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.
3. Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves or colleagues? — Genuine, concrete examples, not general statements of good intentions or awareness.

9.8 Cross-Border Continuity of Care

Non-Negotiable

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

1. Are patients given their own portable health record, in a form they can carry with them? — Something the patient physically or digitally holds themselves, not only a record in the facility's internal system.
2. Is the record kept updated as care continues, not given once and left static? — An outdated record loses much of its value for continuity of care.
3. Does the record include information — medication history, vaccination record — that would be genuinely useful to a different provider in a different country? — Content specifically useful across a border, not just internally relevant notes.

9.9 Camp-Based and Non-Camp Service Model Fit

Non-Negotiable

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

1. Can the facility clearly state which service model it operates under, and why that classification fits its actual context? — A specific, considered answer, not an assumption that one generic approach applies everywhere.
2. Are the facility's specific practices — staffing, scheduling, outreach — genuinely adapted to that model, not copied from a different context? — Real adaptation, not a generic template applied regardless of actual setting.
3. Has the facility considered what changes if its population or context shifts between models over time? — Genuine preparedness for a changing situation, not an assumption the current model is permanent.

9.10 Legal Status Diversity Recognition

Non-Negotiable

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

- 1.** Can staff name the different legal status categories among the patients this facility actually serves? — Specific awareness of asylum seeker, refugee, stateless, and internally displaced distinctions relevant to this context.
- 2.** Does the facility apply a single, uniform assumption about access rights, or does it recognise genuine differences by status? — Genuine differentiation where it legally matters, not a one-size-fits-all approach.
- 3.** Are staff aware of the particular vulnerabilities that can attach to a specific legal status, such as statelessness? — Specific, not generic, awareness of status-linked risk.