

Long-Term Care Standards — Full Guidance

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 61 criteria.

10 standards · 61 criteria · Version 4.0

Standard 1 — Admission & Resident Rights

6 criteria · 5 non-negotiable · 1 core · Version 4.0

CRITERIA IN THIS STANDARD

- 1.1 — Admission Agreement Is Genuinely Understood, Not Just Signed
- 1.2 — Resident Rights Are Disclosed and Actively Explained
- 1.3 — Financial Terms Are Transparent Before Admission Is Finalized
- 1.4 — Transfer and Discharge Protections Are Real, Not Theoretical
- 1.5 — Grievances Are Genuinely Heard and Resolved
- 1.6 — A Comprehensive Assessment Builds One Real Care Plan

1.1 Admission Agreement Is Genuinely Understood, Not Just Signed

NON-NEGOTIABLE

Before or at admission, the resident or their legal representative receives a genuine, plain-language explanation of the admission agreement's actual terms — services included, room configuration, facility-specific rules — with understanding verified, not just a signature obtained

on a document handed over at a stressful, disorienting moment.

In plain terms: Before a resident moves in, they or their representative hear a plain-language explanation of what the admission agreement means — services, rules, costs, rights — and can explain it back.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

An admission agreement is a contract that governs a person's home for the rest of their life. It is typically 20 pages of legal language signed under pressure by a family in crisis. Misunderstanding it leads to disputes about charges, surprise about what is not included, and conflict about rules nobody knew existed. A genuine explanation — a plain-language summary, a conversation, time to ask questions, a teach-back — is the difference between informed agreement and a signature. It also protects the home: a documented explanation is evidence against a later claim of deception.

WHAT GOOD LOOKS LIKE

- A genuine, plain-language explanation is given before or at admission.
- Understanding is actively verified, not assumed from a signature.
- The explanation covers specific facility characteristics and service limitations.

COMMON FAILURE MODES

- The agreement is handed over for signature with no real explanation.
- No verification of understanding happens beyond obtaining a signature.
- Explanation, if given, is generic and doesn't reflect this facility's actual characteristics.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home with a 24-page admission agreement.

BEFORE	The agreement was handed to families to sign at admission, often on the day of arrival. No explanation. Three disputes in the previous year concerned charges families said they had not been told about. All were in the agreement. None had been explained.
ACTION	A two-page plain-language summary was written: what is included, what costs extra, house rules, resident rights, how to complain, how discharge works. The admissions coordinator explains it in a scheduled pre-admission meeting, invites questions, and asks the family to describe the three most important points. The summary is signed alongside the full agreement, and both are given to the family. Interpreters are used where needed.
AFTER	The Monitor reviewed 15 admission files with signed summaries and teach-back notes. Interviewed two families who accurately described what was and was not included. Disputes about charges: none in six months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your admission agreement aloud. Time it. Then ask: could a family in crisis understand this?
2. Write a two-page plain-language summary.
3. Schedule a pre-admission explanation meeting.
4. Ask the family to describe the three key points before signing.

The most common mistake: Handing the agreement over for signature on admission day — no family understands a contract on the day their parent moves into a home.

SELF-ASSESSMENT QUESTIONS

1. Does the resident or legal representative receive a genuine, plain-language explanation of the agreement, not just the document itself? — *A real explanation, not a document handed over for signature*

alone.

Evidence: Admission agreement explanation record

2. Is understanding actively verified — for example, through teach-back — before the agreement is signed? — *Genuine verification, not assumed from a signature.*

Evidence: N/A — tested directly

3. Does the explanation specifically cover facility-specific characteristics and service limitations, not only generic terms? — *Specific to this facility, not a generic admission script.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Explanation happens but is delivered quickly, at a moment when the family is visibly overwhelmed.** — Genuine understanding requires a moment that allows it, not just words spoken regardless of receptiveness.
- **Verification happens for financial terms but not for service limitations or facility rules.** — Every major category of the agreement deserves the same genuine verification.
- **A legal representative is present but the resident themselves, where capable, isn't included in the conversation.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current admission practice for genuine explanation versus document handover.
Week 2	Build a plain-language admission conversation guide covering all major agreement terms.
Week 3	Train admissions staff on teach-back verification technique.
Ongoing	Spot-check family and resident understanding after admission.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Admission conversation observation	Observes an actual admission conversation, or a re-creation of one, for genuine explanation and verification.
DOCUMENT	Agreement documentation review	Reviews admission agreements for specific, facility-characteristic disclosure, not generic template language.
ASK	Family understanding interview	Asks a resident or family member what they understood about the agreement's actual terms.

SUPERVISOR TIPS

- **Ask a recent family member what they remember being told about facility-specific limitations.** — This tests genuine understanding, not just that a document was signed.
- **Ask admissions staff to walk through their actual explanation process for a specific, recent admission.** — A specific, confident answer reveals genuine practice, not a generic policy description.

EVIDENCE BASE

[1] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require disclosure to a resident or potential resident, prior to admission, of the facility's specific characteristics and service limitations as part of a genuine admission agreement 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.

1.2 Resident Rights Are Disclosed and Actively Explained

NON-NEGOTIABLE

Every resident receives a genuine, understandable explanation of their rights — dignity, self-determination, communication and access to persons and services inside and outside the facility — not a rights document filed away unread after admission.

In plain terms: Every resident is told their rights in a way they can understand — dignity, choice, privacy, visits, complaints — and can name some of them.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A resident who knows they have the right to refuse a bath at 6am, to have visitors when they choose, to see their own records, and to complain without fear, is a resident who can protect themselves. A resident who does not know accepts what is done to them. Rights posted on the wall in small print do not inform anyone. Rights explained at admission, in plain language, in the resident's own language, with the resident's cognitive state taken into account, and repeated when asked — those inform. Staff must know the rights too; a right the staff do not respect is not a right.

WHAT GOOD LOOKS LIKE

- Every resident receives a genuine, understandable rights explanation.
- Residents or representatives can describe specific rights in their own words.
- Rights are actively protected in daily practice, not only disclosed once.

COMMON FAILURE MODES

- Rights disclosure is a signed form with no real explanation.
- Residents cannot describe any specific right when asked.
- Daily practice doesn't reflect genuine respect for disclosed rights.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home with a resident rights poster in the lobby.

BEFORE	Rights were on a laminated poster, in 10-point type, in legal language. No resident had been walked through them. When the Coordinator asked ten residents to name one right, two could. Staff assumed residents 'knew.' A resident had been bathed against her expressed wishes because 'it's bath day.'
ACTION	A one-page plain-language rights sheet was written with eight rights in large type and a picture for each. It is explained at admission by a nurse, in the resident's language, with a family member present where the resident has cognitive impairment. It is posted in every room. Staff had a 30-minute session on what each right means in daily practice. Residents' council reviews rights annually.
AFTER	The Monitor asked eight residents to name a right; seven could. Reviewed the sheet in every room and the staff training record. Interviewed a resident who described refusing an activity and being respected. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five residents today: 'What rights do you have here?'
2. Rewrite the rights as eight plain sentences with pictures.
3. Explain them at admission and post them in every room.
4. Train staff on what each right means at 6am on bath day.

The most common mistake: Posting rights in the lobby and believing residents are informed.

SELF-ASSESSMENT QUESTIONS

1. Does every resident receive a genuine, understandable explanation of their rights, not just a document? — *A real explanation, not paperwork filed without discussion.*
Evidence: Rights explanation record
2. Can the resident, or their representative, describe at least one specific right in their own words? — *Tests genuine understanding, not*

just that disclosure technically occurred.

Evidence: N/A — tested directly

3. Are rights actively protected in daily practice, not only disclosed once at admission? — *Genuine, ongoing protection, not a one-time formality.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Rights are explained at admission but never revisited as the resident's situation changes.** — A resident's capacity to exercise rights, and relevant circumstances, can genuinely change over a long stay.
- **Explanation happens but isn't adapted for residents with cognitive impairment.** — A resident with cognitive impairment still has real rights, and disclosure needs genuine adaptation to reach them meaningfully.
- **Rights are respected for most residents but inconsistently for those perceived as difficult or demanding.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current rights disclosure practice for genuine explanation versus paperwork.
Week 2	Build an adapted explanation approach for residents with cognitive impairment.
Week 3	Train staff on recognising and respecting rights in daily practice, not only at admission.
Ongoing	Revisit rights explanation periodically, particularly after a significant change in resident condition.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Rights disclosure review	Reviews documentation of rights explanation, not just a signed acknowledgment form.
ASK	Resident understanding interview	Asks a resident or representative to describe a specific right in their own words.

Method	What	Detail
OBSERVE	Daily practice observation	Observes whether resident rights are genuinely respected in day-to-day facility practice.

SUPERVISOR TIPS

- **Ask a resident directly what rights they remember being told about.** — This tests genuine understanding, not disclosure compliance on paper.
- **Observe daily interactions for genuine respect of self-determination, not just formal rights disclosure.** — This reveals whether rights are lived practice or a one-time administrative step.

EVIDENCE BASE

[2] The United Nations Principles for Older Persons (General Assembly resolution 46/91, 1991) establish that older persons residing in any care or treatment facility should enjoy full respect for their dignity, beliefs, needs, and privacy, and the right to make decisions about their care and the quality of their lives, requiring the facility to protect and promote these rights, not merely state them.

[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.

1.3 Financial Terms Are Transparent Before Admission Is Finalized

NON-NEGOTIABLE

Every charge, included and excluded service, and payment term is disclosed in writing before admission is finalized, with no requirement for a third-party payment guarantee as a condition of admission — not costs that emerge or change only after the resident has already moved in.

In plain terms: Every charge, every included and excluded service, and every payment term is written down and explained before the admission is final — and the family is not asked to guarantee payment from their own money.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Care home fees are the largest expense most families ever face, and the least transparent. The base fee excludes incontinence products, hairdressing, transport, escorts to appointments, and 'extras' that add 20% to the bill. Families discover this on the first invoice. Worse, some homes require a family member to sign as personal guarantor — a practice that is illegal in many jurisdictions and unethical everywhere. Transparency means a complete fee schedule, in writing, before admission, with every exclusion listed and no financial surprises. The family should be able to predict the monthly invoice to within a small margin.

WHAT GOOD LOOKS LIKE

- Complete, written financial disclosure is provided before admission is finalized.
- A third-party payment guarantee is never required as a condition of admission.
- Residents are promptly notified of any change to covered services or charges.

COMMON FAILURE MODES

- Financial terms are incomplete or clarified only after admission.
- A third-party guarantee is required or strongly implied as a condition of admission.
- Cost or coverage changes appear without prior notification.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home with a base fee and unlisted extras.

BEFORE

The fee sheet showed the base rate. Extras were charged as incurred and averaged 18% on top. Families complained. The admission agreement required a family member to sign as 'responsible party' with personal liability. Two families had been threatened with legal action for a relative's unpaid fees.

ACTION

A complete fee schedule was written: base fee, every additional service with its price, the average monthly total for a typical resident, payment terms, what happens if funds run out, and the notice period for fee changes. It is given and explained before admission. The personal guarantee clause was removed. Families are told the average monthly total and shown a sample invoice.

AFTER

The Monitor reviewed the fee schedule, 15 admission files with signed fee acknowledgements, and a sample invoice matching the schedule. Interviewed two families who could state their expected monthly cost. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Compare your fee sheet to your last month's invoices. What was charged that was not on the sheet?
2. List every extra with its price.
3. Give families the average monthly total and a sample invoice before admission.
4. Remove any personal guarantee requirement.

The most common mistake: Quoting the base fee and treating everything else as 'extras the family should have expected.'

SELF-ASSESSMENT QUESTIONS

1. Is every charge and included or excluded service disclosed in writing before admission is finalized? — *Complete, written disclosure before the decision is finalized, not after.*

Evidence: Financial disclosure documentation

2. Is a third-party payment guarantee never required as a condition of admission? — *A firm, specific exclusion, not a judgement call made case by case.*

Evidence: N/A — tested directly

3. Are residents and families notified promptly of any change to covered services or charges during the stay? — *Genuine, timely*

notification, not costs that change silently.

Evidence: Change notification record

COMMON REASONS FOR A PARTIAL ANSWER

- **Base charges are disclosed clearly but ancillary or optional service costs are less transparent.** — Ancillary costs can add up meaningfully and deserve the same transparency as base charges.
- **Disclosure is complete at admission but not repeated when a resident's care needs, and therefore costs, change.** — Financial transparency matters throughout the stay, not only at its start.
- **A third-party guarantee isn't formally required but is informally suggested during the admission conversation.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current financial disclosure practice for completeness and timing.
Week 2	Build a complete, written financial disclosure document covering all charges and terms.
Week 3	Brief admissions staff that third-party guarantees are never required or suggested.
Ongoing	Establish prompt notification practice for any change in covered services or charges.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Financial disclosure review	Reviews written financial disclosure provided before admission for completeness.
ASK	Third-party guarantee policy interview	Asks admissions staff directly whether a third-party payment guarantee is ever required.
DOCUMENT	Change notification review	Reviews records of how residents are notified when covered services or charges change.

SUPERVISOR TIPS

- **Ask to see the actual written financial disclosure given to a specific, recent resident.** — A real, specific document reveals whether disclosure genuinely happens, not just exists as policy.

- **Ask directly whether a family member has ever been asked to personally guarantee payment.** — A direct question often surfaces informal practice a policy review wouldn't catch.

EVIDENCE BASE

[3] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit requiring a third-party guarantee of payment as a condition of admission, and require the facility to inform residents before or at admission of services available and their associated charges.

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

1.4 **Transfer and Discharge Protections Are Real, Not Theoretical**

NON-NEGOTIABLE

A resident is not transferred or discharged except for specific, defined, legally permitted reasons, with genuine advance notice and a real, participatory discharge plan — not moved out with inadequate warning or without a plan for where they will actually go.

In plain terms: A resident cannot be moved out or transferred except for specific, lawful reasons, with proper notice, a written explanation, and a right to appeal — not because they are difficult or their funding changed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Eviction from a care home is eviction from a home. It happens to residents whose dementia has become 'challenging,' whose funding has switched from private to public, whose family has complained too much. It is traumatic — transfer trauma in frail elderly people causes measurable decline and death. Most jurisdictions permit discharge only

for defined reasons: the home cannot meet the resident's needs, the resident endangers others, non-payment after due process, or the home closes. The process requires written notice (typically 30 days), the reason, the destination, and an appeal route. A home that discharges informally is breaking the law and harming residents.

WHAT GOOD LOOKS LIKE

- Every transfer or discharge occurs for a specific, documented, permitted reason.
- Genuine advance written notice is given before transfer or discharge.
- Discharge plans are genuinely developed with resident and family participation.

COMMON FAILURE MODES

- Transfers or discharges happen without a specific, documented, permitted reason.
- Notice is informal, late, or absent.
- Discharge plans are presented as already-finalized decisions.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home that had discharged four residents in a year for 'behavioural reasons.'

BEFORE

Residents with dementia who became agitated were told their needs 'could no longer be met' and given a week to find somewhere else. No written notice, no reason, no appeal. One family reported that the discharge came the week after their funding changed to public. No discharge policy existed.

ACTION

A transfer and discharge policy was written to the national regulation: permitted reasons only; 30 days' written notice with the specific reason, the proposed destination, and the appeal process; a care plan review and attempt to address the issue before any discharge for behaviour; the resident's physician involved; the ombudsman notified. Every proposed discharge is reviewed by the director and the medical lead before notice is given.

AFTER

The Monitor reviewed the policy, two discharge files in the following six months (both for genuine clinical needs, with full notice and documentation), and one proposed discharge that was withdrawn after care plan review. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull the files of every resident discharged in the last two years.
Was there written notice with a lawful reason?
2. Write a discharge policy to your national regulation.
3. Require director and medical review before any notice.
4. Tell residents and families the rules and the appeal route.

The most common mistake: Discharging 'difficult' residents informally — behaviour is a care need, not a discharge reason.

SELF-ASSESSMENT QUESTIONS

1. Does every transfer or discharge occur only for a specific, defined, legally permitted reason? — *A specific, documented reason, not a general judgement call.*

Evidence: Transfer/discharge reason documentation

2. Is genuine advance written notice given to the resident and their representative before transfer or discharge? — *Real, timely written notice, not informal or last-minute communication.*

Evidence: Advance notice record

3. Is the discharge plan genuinely developed with the resident and family, not handed to them as a completed decision? — *Genuine participation, not a plan presented as already finalized.*

Evidence: Discharge plan documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Advance notice is given but doesn't specify the resident's right to appeal the decision.** — Genuine notice includes the resident's actual rights in response, not only the decision itself.
- **Discharge planning involves the family but not the resident directly, even where the resident is capable of participating.** — A capable resident deserves genuine inclusion in decisions about their own discharge.
- **The reason given is technically permitted but documentation doesn't clearly establish it applies to this specific case.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent transfers and discharges for documented, permitted reasons and genuine advance notice.
Week 2	Establish a standard advance notice process including appeal rights information.
Week 3	Build a genuinely participatory discharge planning process involving resident and family.
Ongoing	Audit transfer and discharge documentation for continued compliance.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Transfer reason review	Reviews documentation for a sample of transfers or discharges to confirm specific, permitted reasons.
DOCUMENT	Advance notice review	Reviews records for genuine, timely written notice before transfer or discharge.
ASK	Family participation interview	Asks a family member whether they genuinely participated in developing a discharge plan.

SUPERVISOR TIPS

- **Ask for the actual documentation behind a real, recent transfer or discharge.** — A specific, real case reveals whether the process genuinely functions, not just exists as policy.
- **Ask a family member whether they felt genuinely included in discharge planning, not just informed of a decision.** — This reveals whether participation is real or nominal.

EVIDENCE BASE

[4] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, permit transfer or discharge only for specific defined reasons, require advance written notice, and require a participatory discharge plan developed with the resident and family.

[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.

1.5 Grievances Are Genuinely Heard and Resolved

CORE

Residents and families can voice a grievance through a genuine, accessible process, free from any retaliation, with real evidence that grievances lead to a documented response and, where warranted, an actual change — not a suggestion box that generates no real action.

In plain terms: Residents and families can raise a complaint easily and without fear, and there is evidence that complaints are investigated, answered, and lead to change.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A resident who complains about a care worker and is then treated worse by that care worker has learned not to complain. In a care home, the resident is dependent on the people they might complain

about — retaliation, even subtle, is devastating. The grievance process must be visibly safe: a route that does not go through the care worker (a named manager, a box, an external ombudsman), a written non-retaliation commitment, acknowledgement and response within defined days, and evidence that complaints change things. Families must be able to use it too. Silence is not satisfaction; it is often fear.

WHAT GOOD LOOKS LIKE • A genuine, accessible grievance process is known and used. • Real, documented evidence shows grievances lead to response and action. • Residents and families express genuine confidence about raising concerns without retaliation.	COMMON FAILURE MODES • No accessible grievance process exists, or it's unknown to residents and families. • Grievances are received but produce no documented response or action. • Residents or families express fear of retaliation for raising concerns.
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WORKED EXAMPLE

IN PRACTICE	
<i>A 50-bed care home with a complaints book at the nurses' station.</i>	
BEFORE	The complaints book was at the nurses' station — where residents had to complain in front of staff. Six entries in two years. Interviewed residents said they did not complain because 'it won't change anything' and 'they'll take it out on you.' Families had similar experiences. Nothing had ever changed as a result of a complaint.
ACTION	A grievance process was written: complaints can go to the manager directly, by a sealed box in the lobby, by phone or email, or to the external ombudsman whose number is posted; a written non-retaliation policy signed by every staff member; acknowledgement within 3 days, investigation and written response within 14; monthly review of complaints for patterns at the

quality meeting; a 'You said, we did' board. The residents' council reviews the process quarterly.

AFTER

The Monitor reviewed the log: 28 complaints in six months (up from 3), all acknowledged and responded to; 5 changes made and posted. Interviewed two residents who described complaining without fear. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five residents privately whether they would feel safe complaining. Listen to the reasons.
2. Create routes that bypass the care staff — a sealed box, the manager, the ombudsman.
3. Sign and post a non-retaliation commitment.
4. Make one visible change from a complaint this month.

The most common mistake: Reading a low complaint count as satisfaction — in a care home, it is more often fear.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, accessible process for residents and families to voice a grievance? — *A real, known process, not a theoretical right with no practical channel.*

Evidence: Grievance process documentation

2. Is there real, documented evidence that grievances lead to a response and, where warranted, an actual change? — *Genuine follow-through, not a process that receives complaints without acting on them.*

Evidence: Grievance resolution record

3. Are residents and families confident that raising a grievance carries no risk of retaliation? — *Genuine confidence, not just a stated non-retaliation policy.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A grievance process exists but residents with cognitive impairment have no adapted way to use it.** — Every resident,

regardless of cognitive capacity, deserves a genuine way to have concerns heard.

- **Grievances receive a response but resolution isn't tracked to confirm the underlying issue was actually addressed.** — A response isn't the same as genuine resolution of the concern raised.
- **Families feel comfortable raising concerns but residents themselves are less confident doing so directly.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current grievance process for genuine accessibility and follow-through.
Week 2	Build an adapted grievance channel for residents with cognitive impairment.
Week 3	Establish tracked resolution confirming grievances lead to genuine action.
Ongoing	Monitor grievance patterns and resident/family confidence in the process.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Grievance process review	Reviews the actual, accessible grievance process available to residents and families.
DOCUMENT	Resolution record review	Reviews documented evidence of grievance response and resulting action where warranted.
ASK	Retaliation confidence interview	Asks residents or family members whether they would feel safe raising a concern.

SUPERVISOR TIPS

- **Ask for a real, recent example of a grievance and what actually happened as a result.** — A real example reveals whether the process genuinely functions, not just exists on paper.
- **Ask a resident directly whether they'd feel safe raising a complaint.** — A confident, genuine answer is the clearest evidence of real, retaliation-free practice.

EVIDENCE BASE

[5] The United Nations Principles for Older Persons establish that older persons should be able to live in dignity and security, free of exploitation and abuse, a principle reflected in established long-term care practice as the resident's right to voice grievances without retaliation and prompt facility efforts to resolve them.

[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.

1.6 **A Comprehensive Assessment Builds One Real Care Plan**

NON-NEGOTIABLE

Every resident receives a comprehensive initial assessment, performed by a qualified individual and drawing in other relevant disciplines where the resident’s needs call for it, resulting in one individualized care plan — not a set of disconnected, topic-specific plans with no single document bringing them together. The plan states explicit goals, genuinely involves the resident and family in setting them, and is documented as organisational policy requires.

In plain terms: One real, comprehensive assessment is done by someone qualified to do it, pulling in other specialists when the resident’s situation needs it, and it produces a single care plan with real goals the resident and family actually helped set — not a pile of separate falls, nutrition, and dementia plans that nobody has pulled together into one picture.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A facility can meet every topic-specific requirement in this standard — a genuine falls assessment, a genuine nutrition assessment, genuine dementia care training — and still fail this resident, because nobody ever stepped back and built the one document that says, in plain terms, who this person is, what they want from their remaining time in this facility, and how every department's efforts fit together toward that. Topic-specific plans manage individual risks; only a comprehensive plan, built by someone qualified and involving the resident's own voice, actually manages the person. Without it, care becomes a collection of separately-managed problems rather than a coordinated response to one human being's actual goals.

WHAT GOOD LOOKS LIKE

- One genuine, comprehensive initial assessment exists for every resident, not only the topic-specific ones.
- The assessment is performed by a qualified individual, with other disciplines drawn in when needed.
- One unified care plan states explicit goals the resident and family genuinely helped set.

COMMON FAILURE MODES

- Only topic-specific assessments exist, with no single comprehensive document tying them together.
- The assessment is completed by whoever is available, not someone verifiably qualified.
- The care plan lists interventions with no stated goal, decided without genuine resident involvement.

WORKED EXAMPLE

IN PRACTICE

A resident admitted with multiple topic-specific assessments completed but no unifying plan.

BEFORE

The resident had a falls risk assessment, a nutrition assessment, and dementia care notes — each completed competently by the relevant department. No single document stated what this resident actually wanted from their care, and a new staff member had to read four separate files to understand the whole picture.

ACTION

The facility built a comprehensive initial assessment process, led by a qualified nurse assessor who draws in physical therapy, dietary, and social work as needed, producing one care plan document stating the resident's own stated goals — remaining mobile enough to attend weekly family visits in the common room — with every department's contribution mapped to that goal.

AFTER

The Monitor asked a staff member taking over a shift to describe this resident's actual care goal and found a confident, specific answer traced directly to the unified plan. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Confirm who is qualified to lead a comprehensive initial assessment, and name that role.
2. Build a single care plan template that draws together — not replaces — the topic-specific assessments.
3. Ask residents directly what they want from their time in the facility, and write it into the plan as the stated goal.

The most common mistake: Assuming that a complete set of topic-specific assessments adds up to comprehensive care, when no single document actually states the resident's own goals or brings the separate pieces together into one real plan.

SELF-ASSESSMENT QUESTIONS

1. Is there a single, comprehensive initial assessment for each resident, not only the separate topic-specific assessments required elsewhere in this standard? — *One real, comprehensive evaluation, not an assumption that adding up the falls, nutrition, and dementia assessments equals a comprehensive one.*

Evidence: Comprehensive assessment record

2. Is the assessment performed by a genuinely qualified individual, with other relevant disciplines drawn in where the resident's needs call for it? — *A named, qualified assessor, with real multidisciplinary input when complexity warrants it.*

Evidence: Assessor qualification and discipline involvement record

3. Does the resulting care plan state explicit goals, and was the resident, and family where appropriate, genuinely involved in setting them? — *A real, stated goal and genuine involvement, not a plan decided for the resident and only announced to them.*

Evidence: Care plan goal documentation

4. Is there one document — not scattered, disconnected plans — that a staff member can find and understand as this resident's actual current care plan? — *A single, genuinely unified plan, not separate falls, nutrition, and dementia plans with no document tying them together.*

Evidence: Staff interview at handover

COMMON REASONS FOR A PARTIAL ANSWER

- **Topic-specific assessments are strong but no comprehensive document unifies them.** — Each piece is real, but nobody has built the whole picture.
- **A care plan exists but states interventions without a clearly stated resident goal.** — A list of tasks is not the same as a plan oriented around what the resident actually wants.
- **The resident was informed of the plan but not genuinely involved in shaping its goals.**

IMPLEMENTATION PLAN

When	What
Week 1	Name who is qualified to lead comprehensive initial assessments.
Week 2	Build a unified care plan template drawing together topic-specific assessments.
Week 3	Build a genuine resident/family goal-setting conversation into the admission process.
Ongoing	Audit that every resident has one current, findable, goal-stated care plan.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Comprehensive assessment review	Reviews a resident's file for a single comprehensive assessment and unified care plan, not only topic-specific documents.

Method	What	Detail
ASK	Staff handover interview	Asks a staff member taking over a shift to describe a specific resident's actual stated care goal.

SUPERVISOR TIPS

- **Pick a resident file at random and ask for the one document that states their care goal.** — If the answer requires assembling several separate documents, no real comprehensive plan exists.
- **Ask the resident themselves, where possible, what their care plan's goal is.** — Genuine involvement shows in whether the resident can describe their own stated goal.

EVIDENCE BASE

World Health Organization. Integrated Care for Older People (ICOPE) Guidelines. 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.

← **Long-Term Care Standards — all standards**

Self-assess against these criteria →

Standard 2 — Living Environment & Safety →

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ASF STANDARDS · LONG-TERM CARE · STANDARD 2

Standard 2 — Living Environment & Safety

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

2.1 — Falls Prevention Is Individualized, Not Generic

2.2 — Physical Restraints Are the Last Resort, Not the Default Response

2.3 — The Resident Call System Reaches Staff Immediately, Every Time

2.4 — Fire Safety Follows a Recognized Life Safety Standard

2.5 — Bathroom and Room Configuration Genuinely Support Dignity and Independence

2.1 Falls Prevention Is Individualized, Not Generic

NON-NEGOTIABLE

Every resident undergoes a specific falls risk assessment at admission and after any significant change, with an individualized care plan addressing that resident's actual identified risk factors — not a generic facility-wide falls policy applied identically regardless of individual risk.

In plain terms: Every resident has a falls risk assessment at admission and after any change, and a care plan with precautions specific to them — not the same three

interventions for everyone.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Falls are the leading cause of injury death in care home residents. Half of residents fall each year; a hip fracture halves life expectancy. Most falls have identifiable causes: medications (sedatives, antihypertensives), poor vision, unsafe footwear, urinary urgency, cognitive impairment, an unfamiliar environment. A generic falls plan — 'bed low, call bell in reach, non-slip socks' — does nothing about the sedative or the unlit path to the toilet at night. Individualised means the assessment finds this resident's risk factors and the plan addresses them: medication review, night light, scheduled toileting, hip protectors, physiotherapy.

WHAT GOOD LOOKS LIKE

- Every resident has a specific, individual falls risk assessment.
- Care plans address this specific resident's actual identified risk factors.
- Reassessment genuinely happens after significant condition changes.

COMMON FAILURE MODES

- Falls prevention relies on a generic, facility-wide policy with no individual assessment.
- Care plans list generic falls precautions unrelated to the resident's actual risk factors.
- Assessment happens only once at admission, never updated.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home with 80 falls a year and a generic falls protocol.

BEFORE

Every resident had the same falls plan. Falls were recorded but not analysed. The Coordinator reviewed 20 falls: 12 occurred at night on the way to the toilet; 8 residents who fell were on two or more sedating medications; none had a medication review as part of their plan.

ACTION	A validated falls risk tool (e.g. Morse or STRATIFY adapted for care homes) was adopted at admission, after any fall, and quarterly. The care plan lists this resident's specific risk factors and matching interventions: sedative review with the pharmacist, scheduled toileting for those with urgency, night lighting on the toilet path, physiotherapy for gait, vision check. Post-fall huddles within 24 hours identify what was missing. Falls are trended monthly.
AFTER	The Monitor reviewed 20 care plans with individualised falls interventions, 10 post-fall huddle records, and the monthly trend (falls down 40%, injurious falls down 55%). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Review your last 20 falls: when, where, and what medications was the resident on?
2. Adopt a validated risk tool and use it at admission and after every fall.
3. Write each resident's specific risk factors and matching interventions in their plan.
4. Hold a post-fall huddle within 24 hours.

The most common mistake: Applying the same three precautions to every resident — the resident on three sedatives needs a medication review, not non-slip socks.

SELF-ASSESSMENT QUESTIONS

1. Does every resident undergo a specific falls risk assessment at admission and after any significant change? — *A specific, individual assessment, not a general facility-wide falls policy alone.*

Evidence: Falls risk assessment record

2. Does the resulting care plan address this specific resident's actual identified risk factors? — *Individualized interventions matched to this resident's real risk factors, not generic falls precautions.*

Evidence: Individualized falls care plan

3. Is the falls risk assessment genuinely updated after a significant change in condition, not only at admission? — *A living assessment, not a one-time evaluation that goes stale as the resident's condition changes.*

Evidence: Reassessment record

COMMON REASONS FOR A PARTIAL ANSWER

- **Assessment happens at admission but reassessment after a fall or condition change is inconsistent.** — A resident's risk can change significantly, and reassessment needs to reliably follow those changes.
- **Risk factors are identified but the care plan doesn't specifically address each one individually.** — Identifying a risk factor without a specific, matched intervention doesn't reduce the actual risk.
- **Assessment is thorough for physical risk factors but doesn't consider medication-related fall risk.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current falls risk assessment practice for genuine individualization.
Week 2	Establish a structured reassessment trigger tied to significant condition changes.
Week 3	Ensure care plans specifically address each resident's own identified risk factors.
Ongoing	Audit falls incidents against risk assessments to confirm plans are genuinely followed.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Falls risk assessment review	Reviews falls risk assessments for a sample of residents for specificity and individual relevance.
DOCUMENT	Care plan individualization review	Reviews whether care plans reflect this specific resident's identified risk factors, not generic precautions.

Method	What	Detail
ASK	Reassessment trigger interview	Asks staff what specifically triggers a falls risk reassessment beyond the admission evaluation.

SUPERVISOR TIPS

- **Ask to see a specific resident's falls risk assessment and compare it against their actual care plan.** — A real, matched example reveals whether individualization is genuine practice, not just policy language.
- **Ask what happens to the falls plan after a resident's medication changes.** — This reveals whether reassessment genuinely accounts for modifiable, medication-related risk.

EVIDENCE BASE

[6] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to ensure the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision, assistance, and devices to prevent accidents, including falls.

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.

2.2 Physical Restraints Are the Last Resort, Not the Default Response

NON-NEGOTIABLE

Physical or chemical restraints are never used for staff convenience or resident discipline, only when genuinely required to treat a documented medical symptom, with the least restrictive alternative tried and documented first — not applied as a default response to a resident who is difficult to manage.

In plain terms: Restraint — belts, rails, mittens, sedatives — is never used to make staff's job easier or to punish, only when a specific medical condition requires it, under a written order, for the shortest time, with alternatives tried first.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Restraint in care homes causes death: asphyxiation in bed rails, pressure injuries, deconditioning, terror. It was once routine; it is now recognised as harm. The only justification is a specific medical symptom that cannot be managed otherwise — and even then, the least restrictive method for the shortest time, with a physician's order, consent, monitoring, and documentation. 'Chemical restraint' — a sedative to quiet a resident for staff convenience — is subject to the same rules. The test: would this restraint be used if there were enough staff and the resident's needs were met? If not, it is convenience, not care.

WHAT GOOD LOOKS LIKE

- Restraints are never used for convenience or discipline.
- Restraint use, when it occurs, is tied to a specific, documented medical symptom.
- Less restrictive alternatives are genuinely tried and documented first.

COMMON FAILURE MODES

- Restraints are used to manage a resident who is difficult or time-consuming to supervise.
- Restraint justification is vague or behavioral rather than medically specific.
- Less restrictive alternatives are not genuinely attempted before restraint use.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home with bed rails on most beds and PRN sedatives used nightly.

BEFORE

Bed rails were up on 50 beds 'for safety.' Lap belts were used on residents who 'wandered.'

	PRN lorazepam was given to agitated residents most nights. No restraint policy, no orders, no documentation of alternatives. Two residents had been found trapped in bed rails; one had a fractured femur.
ACTION	A restraint reduction programme was launched: every restraint reviewed by a multidisciplinary team; bed rails removed unless a specific assessment showed benefit and the resident consented; low beds and floor mats replaced rails for fall risk; lap belts eliminated with individualised wandering management (5.3); PRN sedatives reviewed by the pharmacist and physician with behavioural alternatives (5.1) tried first. Any remaining restraint has a physician order, a time limit, 30-minute checks, and monthly review.
AFTER	The Monitor found bed rails on 4 of 70 beds, each with assessment, order, and consent. No lap belts. PRN sedative use down 80%. Reviewed the restraint log and the reduction programme records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk the home tonight and count every bed rail, belt, and PRN sedative given.
2. For each, ask: what specific medical condition requires this?
3. Remove every restraint without a medical justification, starting with rails.
4. Write a restraint policy: last resort, order, time limit, monitoring, review.

The most common mistake: Calling bed rails 'safety equipment' — they are restraints, and they trap and kill.

SELF-ASSESSMENT QUESTIONS

1. Are physical or chemical restraints ever used for staff convenience or resident discipline? — *A firm, specific exclusion — this*

should never happen, not a judgement call made case by case.

Evidence: N/A — tested directly

2. When restraint use is genuinely medically indicated, is it tied to a documented medical symptom, not general behavior management?

— A specific, documented medical justification, not a vague behavioral rationale.

Evidence: Restraint justification documentation

3. Is the least restrictive alternative genuinely tried and documented before restraint use, not skipped as a formality? — *Real, documented attempts at less restrictive options first, not a box checked after the fact.*

Evidence: Least restrictive alternative documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Medical justification is documented but the specific symptom being treated isn't always clearly identified.** — A vague justification is difficult to distinguish from convenience-driven restraint use after the fact.
- **Less restrictive alternatives are considered for new restraint orders but not reconsidered for long-standing ones.** — A resident's need for a restraint can change over time, and ongoing use deserves the same scrutiny as initial use.
- **Staff understand the policy but describe genuine uncertainty about practical alternatives in difficult moments.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current restraint use for documented medical justification versus convenience.
Week 2	Train staff on practical, less restrictive alternatives to restraint use.
Week 3	Establish a documented process requiring alternatives be tried and recorded first.
Ongoing	Review all restraint use, including long-standing orders, on a regular schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Restraint use record review	Reviews restraint use records for documented medical justification, not convenience or discipline.
DOCUMENT	Least restrictive alternative review	Reviews documentation of less restrictive alternatives genuinely tried before restraint use.
ASK	Staff practice interview	Asks staff directly how they'd handle a resident who is difficult to manage, without restraints.

SUPERVISOR TIPS

- **Ask for the specific documented medical symptom behind a real, current restraint use.** — A specific, real answer reveals genuine medical justification versus convenience.
- **Ask staff what they would do instead of restraint for a specific, difficult scenario.** — A confident, specific answer reveals whether alternatives are genuinely practiced, not just known in theory.

EVIDENCE BASE

[7] The United Nations Principles for Older Persons establish the right of older persons to live in dignity and be free of exploitation and physical or mental abuse, a principle reflected in established long-term care practice as the resident's right to be free from physical or chemical restraints imposed for discipline or convenience, requiring the least restrictive alternative when restraint use is genuinely indicated.

[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.

2.3 The Resident Call System Reaches Staff Immediately, Every Time

NON-NEGOTIABLE

Every resident can summon staff assistance through a call system that reaches a staff member or centralized work

area immediately, from their bed, bathroom, and any common area — verified as actually working, not assumed functional because it exists.

In plain terms: Every resident can call for help from bed, chair, and toilet, and the call reaches a staff member immediately — and someone comes.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A resident on the toilet who cannot reach the call bell, a bell that rings at an unstaffed station, a call answered after 20 minutes — each is a resident left alone when they needed help. Falls happen in the wait. Incontinence happens in the wait. Dignity is lost in the wait. The system must be reachable from every position the resident may be in, must alert a staff member who is actually available, and must be answered within a defined time that is measured. A call system that works in theory and rings unanswered in practice is decoration.

WHAT GOOD LOOKS LIKE

- Every resident location has a genuinely functioning call system.
- The system is regularly tested and verified, not assumed working.
- Calls reach staff promptly with genuine response.

COMMON FAILURE MODES

- Call system coverage has gaps in bathrooms or common areas.
- No regular testing verifies the system actually functions.
- Calls go unanswered or are significantly delayed.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home with a call bell system installed in 1998.

BEFORE

Bells rang at the nurses' station, which was often unstaffed. Bathroom pull-cords were out of reach from the toilet in half the rooms. Response time was unmeasured; residents said 'sometimes

twenty minutes.' Three falls in a year occurred while residents waited after ringing.

ACTION

The system was upgraded to page staff directly on portable devices. Bathroom cords were repositioned to be reachable from the toilet and the floor. Response time is logged automatically; target under 3 minutes; reviewed weekly by shift. Residents unable to use the bell (cognitive impairment) have scheduled rounding every hour and a motion sensor. A monthly test checks every bell.

AFTER

The Monitor tested five bells (all reached staff within 90 seconds), reviewed four weeks of response time data (median 2 minutes), and observed rounding for a resident with dementia. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Sit on a toilet in three rooms. Can you reach the cord?
2. Ring a bell and time the response. Do it at 2am.
3. Fix unreachable cords this week.
4. Log response times and set a target.

The most common mistake: Testing the bell rings, not that someone comes.

SELF-ASSESSMENT QUESTIONS

1. Can every resident summon staff assistance from their bed, bathroom, and common areas? — *Coverage in every location a resident might genuinely need to call for help, not just the bedroom.*

Evidence: Call system coverage documentation

2. Is the call system verified as actually functioning, not assumed working because it's installed? — *Genuine, tested verification, not an assumption based on installation alone.*

Evidence: Call system function testing record

3. Does a call genuinely reach a staff member promptly, not go unanswered or significantly delayed? — *Real, prompt response, not a*

system that technically rings without reliable staff response.

Evidence: Response time record

COMMON REASONS FOR A PARTIAL ANSWER

- **Bedroom call systems are reliable but bathroom coverage is inconsistent.** — Bathrooms are a common location for falls and medical emergencies, and coverage there matters as much as bedrooms.
- **The system is tested periodically but response time isn't specifically measured.** — A functioning call system without prompt response doesn't provide the real protection this criterion exists to ensure.
- **Response is prompt during day shifts but slower overnight.**

IMPLEMENTATION PLAN

When	What
Week 1	Physically verify call system coverage and function across all resident areas.
Week 2	Establish a regular testing schedule for call system function.
Week 3	Measure and address response time, including overnight coverage.
Ongoing	Test call system function and response time on a recurring schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Call system coverage check	Physically checks call system presence and function in bedrooms, bathrooms, and common areas.
DOCUMENT	Function testing record review	Reviews records of regular call system testing and maintenance.
OBSERVE	Response time observation	Tests an actual call and observes genuine staff response time.

SUPERVISOR TIPS

- **Test an actual call from a bathroom, not just a bedroom.** — This is where coverage gaps most commonly exist.

- **Time the actual response to a test call, including during an overnight visit if possible.** — Direct observation is the only real evidence of genuine, prompt response, not just system installation.

EVIDENCE BASE

[8] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to be adequately equipped with a resident call system that relays the call directly to a staff member or centralized staff work area.

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.

2.4 **Fire Safety Follows a Recognized Life Safety Standard**

NON-NEGOTIABLE

The facility's fire safety systems and practices — construction, egress, fire-rated doors, staff drills — follow a recognized life safety code appropriate to a residential care setting, verified through regular, genuine drills, not assumed compliant because the building passed an initial inspection.

In plain terms: Fire safety — building construction, exits, fire doors, alarms, sprinklers, staff drills — follows a recognised life safety standard for care homes, not just a general fire certificate.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Care home residents cannot evacuate themselves. Many cannot walk; many cannot understand an alarm. A fire in a care home is a mass casualty event unless the building and the staff are designed to prevent it: fire-rated compartments that contain fire and smoke, self-closing fire doors, sprinklers, an alarm that alerts staff (not just residents), and staff trained to evacuate horizontally into the next

compartment rather than out of the building. NFPA 101 or the national equivalent sets the standard; a general commercial fire certificate does not address the specific vulnerability of residents who cannot save themselves.

WHAT GOOD LOOKS LIKE

- Construction and equipment genuinely comply with an applicable, recognized life safety standard.
- Fire drills are regularly conducted and realistically account for resident mobility and cognitive needs.
- Fire-rated door hardware is verified present and functioning.

COMMON FAILURE MODES

- Compliance with the applicable life safety standard is assumed rather than verified.
- Fire drills are infrequent or don't reflect the actual resident population's real evacuation needs.
- Door hardware doesn't meet fire-rating requirements.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home in a two-storey converted building.

BEFORE

The home had a fire certificate for a commercial building. Fire doors were propped open for convenience. Sprinklers covered the ground floor only. Staff had never practised evacuating bedridden residents. The night shift of three would have had 60 residents to evacuate. No horizontal evacuation plan existed.

ACTION	A life safety review against NFPA 101 (or the national care home standard) was commissioned. Fire doors were fitted with hold-open devices that release on alarm. Sprinklers were extended to the first floor. A compartmentation plan was drawn with horizontal evacuation routes. Staff drills every quarter include moving bedridden residents into the adjacent compartment using evacuation sheets. Night staffing was reviewed against evacuation capacity.
AFTER	The Monitor reviewed the life safety assessment and remediation, observed fire doors closing on alarm test, and reviewed four quarterly drill reports including night-shift drills. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Walk the home: are fire doors propped open? Are there sprinklers on every floor?
2. Commission a life safety review against the care home standard.
3. Draw a horizontal evacuation plan by compartment.
4. Drill with bedridden residents, including at night.

The most common mistake: Planning to evacuate the building — care home residents evacuate to the next compartment, not the car park.

SELF-ASSESSMENT QUESTIONS

1. Does the facility's construction and fire safety equipment follow an applicable, recognized life safety standard? — *Specific, verified compliance with the applicable standard, not general fire safety awareness.*

Evidence: Life safety standard compliance documentation

2. Are fire drills genuinely conducted on a regular schedule, accounting for residents' actual mobility and cognitive needs? — *Real, practiced drills reflecting the actual resident population, not a generic evacuation drill.*

Evidence: Fire drill record

3. Are corridor doors and doors to rooms with flammable materials equipped with proper fire-rated latching hardware? — *Specific, verified hardware compliance, not assumed from the building's age or general condition.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Drills happen regularly but don't specifically practice evacuating residents with significant mobility limitations.** — A drill that doesn't reflect real evacuation challenges provides limited genuine preparation.
- **Fire door hardware is compliant in most areas but not consistently verified throughout the building.** — A single non-compliant door can undermine the fire safety the rest of the building's compliance is meant to provide.
- **Life safety standard compliance was verified at construction but not reconfirmed as the building ages.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current life safety standard compliance documentation and verify current status.
Week 2	Establish or strengthen a fire drill schedule realistically accounting for resident mobility and cognitive needs.
Week 3	Physically verify fire-rated door hardware throughout the facility.
Ongoing	Conduct drills on a recurring schedule and periodically reverify life safety standard compliance.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Life safety standard compliance review	Reviews documentation of compliance with the applicable, recognized life safety standard.
DOCUMENT	Fire drill record review	Reviews fire drill records for regular scheduling and realistic accounting for resident mobility needs.

Method	What	Detail
OBSERVE	Fire door hardware check	Physically checks corridor and flammable-material room doors for proper fire-rated hardware.

SUPERVISOR TIPS

- **Ask to observe or review documentation from an actual, recent fire drill.** — A real, specific drill record reveals whether practice is genuine, not just policy on paper.
- **Physically check a sample of corridor doors for proper fire-rated latching hardware.** — Direct physical verification is the only real evidence of genuine compliance.

EVIDENCE BASE

[9] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to meet an applicable, recognized fire and life safety standard, including fire-rated corridor doors with positive latching hardware.

[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.

Bathroom and Room Configuration

2.5 Genuinely Support Dignity and Independence

CORE

Resident rooms and bathroom facilities are configured to genuinely support privacy, dignity, and the greatest possible independence — private or accessible bathroom facilities, adequate space, personal storage — not merely meeting a minimum institutional standard.

In plain terms: Rooms and bathrooms are set up so residents can be private, dignified, and as independent as possible — a door that closes, a toilet they can use alone, space for their own things.

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

WHY THIS MATTERS

A resident who shares a room with a stranger, uses a toilet with no door, and has no space for a photograph of their late husband is not living in a home; they are stored. Dignity is physical: a lockable door (that staff can open in emergency), a bathroom with grab rails and a raised toilet seat so the resident can manage alone, a wardrobe and shelf for personal belongings, a chair for a visitor. Independence is physical: a room layout the resident can navigate with a walker, a bathroom they can use without calling for help. These are not luxuries; they are the difference between a resident who declines and one who does not.

WHAT GOOD LOOKS LIKE

- Bathroom facilities are genuinely private and accessible for every resident.
- Room configuration provides adequate space and personal storage.
- Residents report genuine, respected privacy in daily practice.

COMMON FAILURE MODES

- Bathroom facilities are distant, shared in ways that compromise privacy, or difficult to access.
- Room space and storage are minimal, institutional, and inadequate.
- Privacy is routinely compromised by staff or facility practice.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home with 20 double rooms and shared bathrooms.

BEFORE

Double rooms had a curtain between beds. Bathrooms were down the corridor, shared by six, with no grab rails. Residents who could have toileted independently were dependent because they could not manage the shared bathroom alone. Personal belongings were limited to one shelf. Doors had no locks.

ACTION

A phased refurbishment: grab rails, raised seats, and lever taps in all bathrooms; two shared bathrooms converted to en-suite for the highest-need rooms; privacy locks fitted to all doors with staff override; a wardrobe, shelf, and pinboard in every room; residents encouraged to bring

furniture and photographs. Double rooms are now used only by choice (couples, friends). A resident-led room review is done at admission.

AFTER

The Monitor inspected ten rooms and five bathrooms: locks, rails, personal belongings, visitor chairs. Interviewed three residents who described toileting independently and personalising their rooms. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Sit in a resident's room. Can they lock the door? Is there space for their things? Could they use the bathroom alone?
2. Fit grab rails and raised seats in every bathroom this quarter.
3. Fit privacy locks with staff override.
4. Give every resident a wardrobe, shelf, and pinboard.

The most common mistake: Removing privacy 'for safety' — a resident who cannot close their door has lost more than they have been protected from.

SELF-ASSESSMENT QUESTIONS

1. Does every resident have private or genuinely accessible bathroom facilities meeting the applicable standard? — *Genuine accessibility and privacy, not a distant or shared facility that functions poorly in practice.*

Evidence: Bathroom facility documentation

2. Does room configuration provide adequate space and personal storage for the resident's own belongings? — *Real, adequate space, not a minimal institutional footprint.*

Evidence: N/A — tested directly

3. Do residents have genuine privacy in their own room, not routinely compromised by staff or facility practice? — *Real, respected privacy, not privacy that exists on paper but is routinely overridden in practice.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Bathroom facilities meet minimum requirements but aren't genuinely convenient for residents with mobility limitations.** — Technical compliance doesn't guarantee genuine day-to-day accessibility for the actual resident population.
- **Personal storage exists but is too limited for residents to keep meaningful personal belongings.** — Personal belongings often carry real emotional significance for long-term residents, beyond mere storage capacity.
- **Privacy is respected by most staff but inconsistently by some, particularly during personal care.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current bathroom and room configuration against genuine dignity and accessibility standards.
Week 2	Address any gaps in bathroom accessibility or personal storage adequacy.
Week 3	Train staff specifically on consistent privacy practice, particularly during personal care.
Ongoing	Gather resident feedback on genuine privacy and dignity in daily living.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Bathroom facility check	Physically verifies bathroom facility accessibility and privacy for resident rooms.
OBSERVE	Room configuration check	Assesses room space and personal storage adequacy directly.
ASK	Privacy practice interview	Asks residents whether their privacy is genuinely respected in daily practice.

SUPERVISOR TIPS

- **Ask a resident directly whether their privacy is genuinely respected, not just technically provided.** — This tests lived experience, not facility design alone.

- **Observe an actual room and bathroom configuration directly, not just review facility specifications.** — Direct observation reveals genuine day-to-day functionality, not just compliance on paper.

EVIDENCE BASE

[10] The United Nations Principles for Older Persons establish that older persons should be able to live in environments that are safe and adaptable to personal preferences, a principle reflected in established long-term care practice as requiring each resident room to be equipped with or located near toilet and bathing facilities supporting genuine dignity and independence.

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.

← **Long-Term Care
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 1 — Admission
& Resident Rights**

**Standard 3 — Personal Care
& Daily Living →**

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Standard 3 — Personal Care & Daily Living

5 criteria · 3 non-negotiable · 2 core · Version 3.0

CRITERIA IN THIS STANDARD

- 3.1 — Activities of Daily Living Support Prevents Unnecessary Decline
- 3.2 — Nutrition and Hydration Are Individualized and Actively Monitored
- 3.3 — Weight Loss Is Caught Early, Using a Specific Threshold
- 3.4 — Food and Activities Reflect Genuine Cultural and Personal Preference
- 3.5 — A Qualified Activities Program Provides Genuine Social Engagement

3.1 Activities of Daily Living Support Prevents Unnecessary Decline

NON-NEGOTIABLE

A resident's ability to perform activities of daily living — hygiene, mobility, eating, toileting — is actively supported to prevent avoidable decline, with any diminution genuinely tied to an unavoidable clinical cause, documented specifically, not assumed as a normal part of aging or long-term residence.

In plain terms: Residents are helped to keep doing what they can — walking, washing, eating, toileting — rather than having it done for them because it is faster. Decline that is not medically necessary is prevented.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A resident who can walk to the dining room but is wheeled because it is quicker will stop being able to walk within weeks. A resident who can feed herself slowly but is fed because the tray must be cleared will lose the ability. Deconditioning is the most preventable harm in long-term care and the most common. Every task done for a resident who could do it themselves takes something away. Restorative care means: assess what the resident can do, support them to keep doing it (time, equipment, encouragement), and measure function over time so decline is detected and addressed — not accepted as inevitable.

WHAT GOOD LOOKS LIKE

- ADL support genuinely maintains resident capability, not just completes tasks.
- Any decline is tied to a specific, documented, unavoidable clinical cause.
- Care plans are genuinely reviewed and adjusted as ability changes.

COMMON FAILURE MODES

- Staff routinely complete ADL tasks for residents who could do them with support.
- Decline is assumed as normal aging without specific clinical justification.
- Care plans remain static despite genuine changes in resident ability.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home where task completion was prioritised over resident independence.

BEFORE

Care assistants completed morning care as fast as possible: washing, dressing, and transferring residents rather than supporting them to do it. Residents who walked in were in wheelchairs

within months. Functional status was not measured. Staff said 'there isn't time to let them do it themselves.'

ACTION

A restorative care approach was adopted: every resident's functional abilities (Barthel or equivalent) are assessed at admission and monthly; the care plan states what the resident does themselves and what support they need; care assistants are trained to 'do with, not for'; time is allocated accordingly; a mobility programme ensures every ambulant resident walks daily. Monthly function scores are reviewed; any decline triggers review.

AFTER

The Monitor reviewed 20 care plans with functional goals, six months of monthly function scores (decline halved), and observed care assistants supporting rather than doing. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch morning care for three residents. How much do they do themselves?
2. Assess every resident's function with a standard tool.
3. Write in each plan what they do themselves.
4. Measure function monthly and act on decline.

The most common mistake: Doing it for the resident because it is faster — you are trading five minutes today for their independence forever.

SELF-ASSESSMENT QUESTIONS

1. Is ADL support genuinely aimed at maintaining the resident's own ability, not simply completing the task for them? — *Support that maintains capability, not task completion that bypasses it.*
Evidence: ADL care plan and approach documentation

2. When ADL decline occurs, is it specifically tied to a documented, unavoidable clinical cause? — *A specific, documented clinical reason,*

not an assumption that decline is simply expected.

Evidence: Decline documentation and clinical justification

3. Are care plans reviewed and adjusted as a resident's ADL ability changes, in either direction? — Genuine, ongoing adjustment, not a static plan set once and left unchanged.

Evidence: ADL care plan review record

COMMON REASONS FOR A PARTIAL ANSWER

- **Ability-maintaining support happens during less busy periods but tasks are completed directly when time is short.** — Genuine support needs to hold up under real time pressure, not only when convenient.
- **Decline is documented but the specific clinical cause isn't always clearly identified.** — A vague justification is difficult to distinguish from decline that was actually preventable.
- **Care plans are reviewed on schedule but don't consistently reflect genuine changes in resident ability.**

IMPLEMENTATION PLAN

When	What
Week 1	Observe current ADL support practice for genuine ability-maintaining approach.
Week 2	Train staff specifically on supporting rather than replacing resident capability.
Week 3	Establish specific clinical documentation requirements for any ADL decline.
Ongoing	Review and adjust ADL care plans as resident ability genuinely changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	ADL support practice observation	Observes actual ADL assistance for genuine ability-maintaining support versus task completion.
DOCUMENT	Decline documentation review	Reviews documented ADL decline for specific, genuine clinical justification.

Method	What	Detail
DOCUMENT	Care plan review record check	Reviews whether ADL care plans are genuinely reviewed and adjusted as ability changes.

SUPERVISOR TIPS

- **Observe an actual ADL assistance interaction, particularly during a busy period.** — This is where the real difference between support and task completion is most visible.
- **Ask for a specific example of documented decline and its clinical justification.** — A real, specific example reveals whether justification is genuine, not just assumed.

EVIDENCE BASE

[11] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to provide necessary care and services to ensure a resident's abilities in activities of daily living do not diminish unless the individual's clinical condition demonstrates the diminution was unavoidable.

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.

3.2 Nutrition and Hydration Are Individualized and Actively Monitored

NON-NEGOTIABLE

Every resident receives a nourishing diet meeting their individual nutritional and special dietary needs, with hydration and eating assistance actively provided as needed — not a standardized menu applied uniformly regardless of individual requirements.

In plain terms: Every resident's diet and fluids match their individual needs — therapeutic diet, texture, preferences, cultural requirements — and eating and drinking are watched and recorded so problems are caught.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Malnutrition and dehydration are endemic in care homes and are causes, not consequences, of decline. The resident with dysphagia who gets regular texture chokes. The diabetic who gets the same pudding as everyone else has unstable glucose. The resident who dislikes the food eats nothing and nobody notices. The resident who cannot lift the cup does not drink. Individualised means: a nutrition and hydration assessment; a diet that matches needs and preferences; food and fluid intake monitored — not 'ate well' but what and how much; and action when intake drops. The dietitian, the kitchen, and the care staff must be connected.

WHAT GOOD LOOKS LIKE

- Every resident's diet genuinely reflects their individual needs.
- Eating and drinking assistance is actively provided to residents who need it.
- A qualified dietitian is genuinely involved in individual nutrition planning.

COMMON FAILURE MODES

- A standardized menu is applied regardless of individual dietary needs.
- Residents needing assistance are left to manage eating or drinking alone.
- Nutrition plans lack genuine professional dietitian involvement.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home with a single menu and no intake monitoring.

BEFORE

All residents received the same meals with texture modification for those on a list. Intake was recorded as 'good/fair/poor' by impression. Three residents had lost significant weight in three months; nobody had connected it to intake. Fluid intake was not recorded. Two residents had been admitted to hospital with dehydration.

ACTION

A nutrition and hydration assessment at admission and quarterly, including swallow screen, preferences, cultural needs, and ability to eat independently. Individual diet cards in the kitchen and at the dining table. Food and fluid charts for at-risk residents record actual amounts. Hydration rounds every two hours with a target of 1.5 litres daily. The dietitian reviews charts weekly and adjusts. Meals are protected time; residents needing assistance are helped one-to-one.

AFTER

The Monitor reviewed 20 nutrition assessments, food and fluid charts with actual amounts, dietitian review records, and the hospital admission rate for dehydration (zero in six months). Observed a protected mealtime. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull the weights of every resident for the last three months.
Who lost weight? Was it noticed?
2. Assess every resident's nutrition, swallow, and preferences.
3. Record actual amounts eaten and drunk for anyone at risk.
4. Start hydration rounds and protected mealtimes.

The most common mistake: Recording 'ate well' — a resident who ate half a slice of toast 'ate well' by the standards of a busy assistant.

SELF-ASSESSMENT QUESTIONS

1. Does every resident's diet reflect their individual nutritional and special dietary needs, not a uniform standard menu? — *Genuine individualization, not a single menu applied regardless of individual requirements.*

Evidence: Individual nutrition plan documentation

2. Is assistance with eating and drinking actively provided to residents who need it, not left for the resident to manage alone? — *Real, active assistance, not passive availability of food and drink alone.*

Evidence: N/A — tested directly

3. Is a qualified dietitian or nutrition professional genuinely involved in developing individual nutrition plans? — *Genuine professional involvement, not a generic plan without individual clinical input.*
Evidence: Dietitian involvement record

COMMON REASONS FOR A PARTIAL ANSWER

- **Special dietary needs are accommodated for major conditions but not consistently for less common ones.** — Every documented dietary need carries real risk if genuinely unaddressed, not only the most common ones.
- **Assistance is provided but rushed during busy mealtime periods.** — Rushed assistance can result in inadequate intake even when technically provided.
- **Dietitian involvement happens at initial assessment but isn't revisited as a resident's condition changes.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current nutrition planning for genuine individualization versus standardized menus.
Week 2	Strengthen dietitian involvement in individual nutrition plan development.
Week 3	Observe and address mealtime assistance practice, particularly during busy periods.
Ongoing	Revisit nutrition plans as resident condition changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Individual nutrition plan review	Reviews nutrition plans for a sample of residents for genuine individualization.
OBSERVE	Eating and drinking assistance observation	Observes an actual mealtime for genuine, active assistance to residents who need it.
DOCUMENT	Dietitian involvement review	Reviews evidence of genuine dietitian or nutrition professional involvement in individual plans.

SUPERVISOR TIPS

- **Observe an actual mealtime, particularly for residents who need eating assistance.** — Direct observation reveals whether assistance is genuine and adequate, not rushed or assumed.
- **Ask how a specific resident's special dietary need is actually accommodated in practice.** — A specific, real answer reveals genuine individualization, not policy language alone.

EVIDENCE BASE

[12] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require the facility to provide each resident a nourishing, palatable, well-balanced diet meeting individual nutritional and special dietary needs, with assistance provided as needed.

[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.

3.3 Weight Loss Is Caught Early, Using a Specific Threshold

NON-NEGOTIABLE

Resident weight is monitored on a defined schedule, with a specific, recognised threshold for significant weight loss triggering immediate clinical review — not weight changes noticed informally or only after they become visually apparent.

In plain terms: Every resident is weighed on a set schedule, and a specific threshold — 5% in a month, 10% in six months — triggers an investigation, not a note in the file.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Weight loss is the earliest measurable sign of almost everything that goes wrong in a care home resident: cancer, depression, dysphagia, poor food, dental pain, medication side effects, neglect. Caught at 5%, it is reversible; at 15%, the resident is frail, immobile, and dying.

Weighing monthly (weekly for at-risk) with a defined threshold — the internationally recognised 5% in 30 days or 10% in 180 days — that automatically triggers a review (dietitian, physician, medication, mood, oral health) turns weight into an early warning system. Weighing without a threshold is data without a purpose.

WHAT GOOD LOOKS LIKE

- Weight is monitored on a defined, consistently followed schedule.
- The specific threshold reliably triggers immediate clinical review.
- Monitoring frequency genuinely increases once significant loss is identified.

COMMON FAILURE MODES

- Weight monitoring is irregular or informal.
- The threshold, even when met, doesn't reliably trigger review.
- Monitoring frequency doesn't change after significant weight loss is identified.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home that weighed residents 'regularly.'

BEFORE

Weights were taken when someone remembered — gaps of three to six months were common. There was no threshold and no automatic response. The Coordinator reviewed 30 residents: 8 had lost more than 10% in six months; 2 had lost over 20%. None had a documented investigation.

ACTION

A weighing protocol was written: every resident monthly on the same calibrated scale, weekly if at risk; weights entered in a register that automatically flags 5%/30-day or 10%/180-day loss; a flag triggers a review within 7 days covering intake, swallow, mood, oral health, medications, and disease; the outcome is a care

plan change or a physician referral. The register is reviewed by the nurse manager weekly.

AFTER

The Monitor reviewed the register with monthly weights for all residents, 12 flagged cases each with a documented review and action, and the calibration record for the scale. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull every resident's weights for six months. Who has lost 5% or more?
2. Weigh everyone monthly on one calibrated scale.
3. Set the 5%/30-day and 10%/180-day thresholds in a register.
4. Investigate every flag within a week.

The most common mistake: Weighing residents and filing the number — without a threshold and a response, the weight is just a number.

SELF-ASSESSMENT QUESTIONS

1. Is resident weight monitored on a defined, regular schedule, not informally or irregularly? — *A specific, scheduled monitoring interval, not ad hoc weighing.*

Evidence: Weight monitoring schedule and record

2. Does the specific 5% in 30 days or 10% in 180 days threshold trigger immediate clinical review? — *A specific, recognised threshold, not a vague sense that weight loss seems concerning.*

Evidence: Significant weight loss response record

3. Once significant weight loss is identified, does monitoring frequency genuinely increase? — *Real, increased monitoring, not the same schedule continued regardless.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Monthly weighing happens consistently but the specific percentage calculation isn't always performed.** — Recording weight without calculating against the specific threshold misses the actual early-warning value.

- **Clinical review happens for weight loss but not consistently within a genuinely prompt timeframe.** — The protective value of early identification depends on genuinely prompt follow-up, not eventual review.
- **Increased monitoring is ordered but not consistently followed through in practice.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current weight monitoring schedule and threshold calculation practice.
Week 2	Establish consistent, systematic threshold calculation against the specific benchmark.
Week 3	Establish a defined, prompt clinical review process triggered by the threshold.
Ongoing	Audit monitoring frequency increases following identified significant weight loss.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Monitoring schedule review	Reviews the weight monitoring schedule and actual adherence to it.
DOCUMENT	Threshold response review	Reviews records for genuine, immediate clinical review when the significant weight loss threshold is met.
DOCUMENT	Increased monitoring review	Reviews whether monitoring frequency genuinely increases after significant weight loss is identified.

SUPERVISOR TIPS

- **Ask for a specific, real example of significant weight loss and the resulting clinical response.** — A real example reveals whether the threshold genuinely triggers action, not just gets recorded.
- **Check whether the specific percentage calculation is actually performed, not just weight recorded.** — This is the precise mechanism that makes early identification possible.

EVIDENCE BASE

[13] Established long-term care clinical practice recognizes significant unintended weight loss — commonly defined as approximately 5 percent in 30 days or 10 percent in 180 days — as a threshold requiring active identification, response, and increased monitoring frequency once loss is identified.

[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.

3.4 Food and Activities Reflect Genuine Cultural and Personal Preference

CORE

Food and activities genuinely reflect each resident's cultural, religious, and personal preferences — with documented, active effort to learn these preferences even from a resident with dementia or communication barriers, not a standardized program applied uniformly regardless of individual background.

In plain terms: The food and the activities reflect who each resident actually is — their culture, religion, and personal preferences — and the home makes a real effort to find out and accommodate.

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

WHY THIS MATTERS

A Muslim resident served pork. A Hindu resident served beef. A Jewish resident with no kosher option. A resident who loved gardening offered bingo. A resident who has always eaten rice offered potatoes daily. These are not small things: food and meaningful activity are what make a place a home, and their absence makes it an institution. The effort must be documented: a preference assessment at admission, a kitchen that can accommodate, an activities programme built from what residents actually want, and a periodic check that it is happening. 'We treat everyone the same' means everyone gets the majority's food.

WHAT GOOD LOOKS LIKE

- Food and activities genuinely reflect individual cultural, religious, and personal preferences.
- Active, documented effort exists to learn preferences from residents with communication barriers.
- Learned preferences are genuinely reflected in practice, not just recorded.

COMMON FAILURE MODES

- A standardized program is applied uniformly regardless of individual background.
- No documented effort exists to learn preferences from residents with communication barriers.
- Preferences are recorded but not genuinely acted on.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home in a diverse city with a single Western menu and a standard activities calendar.

BEFORE

The menu was the same for everyone. Three Muslim residents were served food they could not eat and lost weight. A Hindu resident's family brought all his food. Activities were bingo, films, and singalongs; participation was under 30%. No preference assessment existed.

ACTION

A cultural and personal preference assessment was added to admission: dietary laws, food preferences, faith practices, lifelong interests, meaningful roles. The kitchen introduced halal, kosher-style, and vegetarian options and a weekly meal from a resident's culture. Activities were rebuilt from the assessments: a gardening group, a men's club, a faith service, a cooking group, individual interest pursuits. Participation is tracked and preferences reviewed quarterly with the resident.

AFTER

The Monitor reviewed 20 preference assessments, the diversified menu, the activities calendar built from resident interests, and participation data (30% → 68%). Interviewed a

Muslim resident who described the food as 'finally mine.' Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask ten residents what they miss most about food and activities from their life before.
2. Add a preference assessment to admission.
3. Change one meal a week to a resident's culture.
4. Replace one generic activity with one built from stated interests.

The most common mistake: Offering a standard menu and calendar and expecting residents to adapt — they are at home; the home should adapt.

SELF-ASSESSMENT QUESTIONS

1. Do food and activities genuinely reflect individual residents' cultural, religious, and personal preferences? — *Genuine, individual reflection, not a standardized program applied uniformly.*

Evidence: Preference accommodation documentation

2. For residents with dementia or communication barriers, is there documented, active effort to learn their preferences? — *Specific, documented effort, not an assumption that preferences can't be learned.*

Evidence: Preference-learning documentation for residents with communication barriers

3. Are learned preferences actually reflected in what's provided, not just recorded without follow-through? — *Genuine follow-through, not preferences noted but not actually acted on.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Major religious dietary requirements are accommodated but more individual personal preferences are not.** — Personal, non-religious preferences still carry real meaning for a resident's daily quality of life.
- **Effort to learn preferences happens at admission but isn't revisited as dementia progresses and communication changes.** — A resident's ability to express preference, and preferences themselves, can genuinely change over time.

- **Preferences are documented but the connection between documentation and actual daily provision is inconsistent.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current preference accommodation for genuine individualization versus standardized programming.
Week 2	Establish a specific, documented process for learning preferences from residents with communication barriers.
Week 3	Build a clear connection between documented preferences and actual daily food and activity provision.
Ongoing	Revisit preference documentation as residents' communication ability changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Preference accommodation review	Reviews evidence that food and activities genuinely reflect individual resident preferences.
DOCUMENT	Communication barrier effort review	Reviews documented effort to learn preferences from residents with dementia or communication barriers.
OBSERVE	Follow-through observation	Checks whether documented preferences are genuinely reflected in what's actually provided.

SUPERVISOR TIPS

- **Ask staff how they learned a specific resident's preferences, particularly one with dementia.** — A specific, real example reveals genuine effort, not an assumption preferences can't be learned.
- **Compare documented preferences against what's actually provided to a specific resident.** — This reveals whether documentation translates into genuine practice.

EVIDENCE BASE

[14] The United Nations Principles for Older Persons establish that older persons should be able to live in environments adaptable to personal preferences, a principle reflected in established long-term care practice as the facility's responsibility to make reasonable efforts to learn and accommodate each resident's cultural and personal food preferences, including documented steps to learn preferences from residents facing barriers to expressing them directly.

[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.

3.5

A Qualified Activities Program Provides Genuine Social Engagement

CORE

The facility provides an ongoing activities program led by a genuinely qualified activities professional, offering real, varied social and recreational engagement — not passive entertainment like a television left on, or a program that exists on paper without genuine resident participation.

In plain terms: The home runs a real activities programme led by someone qualified to do it, with varied things to do every day — not a television and an occasional singalong.

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

WHY THIS MATTERS

Boredom in a care home is not a nuisance; it is a cause of depression, agitation, decline, and death. A resident with nothing to do sits in a chair, stops moving, stops talking, stops eating. A qualified activities coordinator — trained in gerontology, occupational therapy, or a recognised activities qualification — designs a programme that meets residents' cognitive, physical, social, and spiritual needs: exercise, creative work, outings, music, faith, conversation, one-to-one for those

who cannot join groups. The programme runs every day including weekends, is documented, and is evaluated by participation and resident feedback.

WHAT GOOD LOOKS LIKE

- The activities program is led by a genuinely, verifiably qualified professional.
- The program offers real, varied engagement matched to individual interests.
- Genuine resident participation is observed, not just programmed availability.

COMMON FAILURE MODES

- The activities role is filled informally without meeting defined qualification criteria.
- The program defaults to passive entertainment with little genuine variety.
- Activities exist on the schedule but residents don't genuinely participate.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home where activities were run by a care assistant when she had time.

BEFORE

Activities happened two or three afternoons a week: television, bingo, occasional music. No weekend activities. Residents with dementia or immobility were excluded. No one on the staff had activities training. Participation was under 25%; most residents spent the day in a chair.

ACTION

A qualified activities coordinator (accredited course) was appointed. A seven-day programme was built with morning and afternoon sessions: exercise, art, music, gardening, reminiscence, faith, outings, and structured one-to-one for residents who cannot join groups. Care assistants received activities training and support sessions. Participation is recorded per resident; the programme is reviewed monthly with the residents' council.

AFTER

The Monitor reviewed the seven-day programme, the coordinator's qualification, participation records (25% → 75%), and one-to-one records for bedbound residents. Observed a morning exercise group. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count how many residents took part in an activity yesterday. And on Saturday.
2. Appoint or train a qualified activities coordinator.
3. Build a seven-day programme with something every morning and afternoon.
4. Record who participates and review monthly.

The most common mistake: Counting the television as an activity.

SELF-ASSESSMENT QUESTIONS

1. Is the activities program led by a genuinely qualified activities professional meeting defined qualification criteria? — *Specific, verified qualification, not simply a staff member assigned the role informally.*

Evidence: Activities professional qualification record

2. Does the program offer real, varied engagement matched to individual resident interests, not passive entertainment alone? — *Genuine variety and individual relevance, not a single default activity like television.*

Evidence: Activities program schedule and content

3. Is genuine resident participation observed, not just a program that exists on paper? — *Real, observed participation, not activities offered without residents actually engaging.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The activities professional is qualified but the program isn't adapted for residents with significant cognitive impairment.** — Meaningful engagement needs to be genuinely accessible to residents across the full range of cognitive ability.

- **Variety exists on the schedule but actual attendance is concentrated in a small group of residents.** — A program's real value depends on genuinely reaching residents broadly, not just being available.
- **Group activities are offered but residents who prefer individual engagement have fewer genuine options.**

IMPLEMENTATION PLAN

When	What
Week 1	Review activities professional qualification against defined criteria.
Week 2	Assess program variety and adaptation for residents with cognitive impairment.
Week 3	Establish tracking of genuine resident participation, not just program offerings.
Ongoing	Review participation patterns and adjust programming to reach residents more broadly.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Activities professional qualification review	Reviews the qualification of the person leading the activities program against defined criteria.
DOCUMENT	Program content review	Reviews the activities program schedule for genuine variety matched to resident interests.
OBSERVE	Participation observation	Observes an actual activity for genuine resident participation, not passive presence alone.

SUPERVISOR TIPS

- **Observe an actual activity session directly, watching for genuine participation, not passive presence.** — Direct observation reveals whether engagement is real, not just scheduled.
- **Ask to see the activities professional's specific qualification credentials.** — Specific, verifiable credentials are the real evidence of genuine qualification, not an assumed title.

EVIDENCE BASE

[15] The United Nations Principles for Older Persons establish that older persons should be able to pursue opportunities for the full development of their potential and remain integrated in society, a principle reflected in established long-term care practice as requiring an ongoing activities program directed by a qualified activities professional to meet the interests and support the physical, mental, and psychosocial well-being of each resident.

[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.

← **Long-Term Care
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 2 — Living
Environment & Safety**

**Standard 4 — Clinical &
Medical Care →**

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Standard 4 — Clinical & Medical Care

5 criteria · 5 non-negotiable · 0 core · Version 3.0

CRITERIA IN THIS STANDARD

- 4.1 — Monthly Pharmacist Medication Review Actually Catches Unnecessary Drugs
- 4.2 — Psychotropic Medications Require a Documented, Specific Diagnosis, Not General Behavior Management
- 4.3 — Gradual Dose Reduction Is Genuinely Attempted for Psychotropic Medications
- 4.4 — PRN Psychotropic Orders Are Time-Limited and Re-Evaluated, Not Renewed Automatically
- 4.5 — Infection Control Follows a Defined, Facility-Specific Program

4.1 Monthly Pharmacist Medication Review Actually Catches Unnecessary Drugs

NON-NEGOTIABLE

A licensed pharmacist reviews every resident's complete drug regimen at least monthly, with any irregularity — excessive dose, excessive duration, inadequate monitoring, inadequate indication — specifically reported to the attending physician and acted upon, not a review that occurs on schedule but produces no real consequence.

In plain terms: A pharmacist reviews every resident's full medication list at least monthly and actually finds and reports unnecessary, excessive, or dangerous drugs — with evidence that the findings lead to changes.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The average care home resident takes nine medications. Many are unnecessary — started years ago for a problem that resolved, continued by habit, prescribed by different doctors who never spoke. Polypharmacy causes falls, confusion, kidney damage, and death. A monthly pharmacist review — every drug, every dose, every interaction, every duplicate, every drug without a current indication — finds these. But finding is not enough: the pharmacist's recommendations must go to the physician, and the physician must respond. A review that produces a report nobody acts on is a review without effect.

WHAT GOOD LOOKS LIKE

- Every resident receives a genuine, complete monthly pharmacist review.
- Irregularities are specifically reported to the attending physician, medical director, and director of nursing.
- Real evidence shows reported irregularities are genuinely acted upon.

COMMON FAILURE MODES

- Pharmacist review is inconsistent, partial, or lapses for some residents.
- Irregularities are identified but not specifically reported to the required individuals.
- Reports produce no documented action or resolution.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home with a contracted pharmacist who reviewed records quarterly.

BEFORE

The pharmacist reviewed medication administration records quarterly and wrote a

report. The physician rarely read it. The Coordinator reviewed 30 residents' medications with the pharmacist: average 10.5 drugs; 40% had at least one drug with no current indication; 6 had two anticholinergics; 3 had a duplicate.

ACTION

The pharmacist review became monthly, structured with a validated tool (STOPP/START or equivalent), with each finding categorised by urgency. Recommendations go to the physician with a required response (accepted, declined with reason) within 14 days. Declined recommendations are reviewed at the medical advisory meeting. The home tracks the number of recommendations, acceptance rate, and average drugs per resident.

AFTER

The Monitor reviewed six months of pharmacist reviews with physician responses (acceptance rate 78%), and the trend in average drugs per resident (10.5 → 8.1). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count the drugs for ten residents. Average over eight is a flag.
2. Move pharmacist review to monthly with a validated tool.
3. Require a physician response to every recommendation within 14 days.
4. Track drugs per resident monthly.

The most common mistake: A pharmacist review that produces a report nobody acts on.

SELF-ASSESSMENT QUESTIONS

1. Does a licensed pharmacist review every resident's complete drug regimen at least monthly? — *A genuine, complete review, not a partial check or one that lapses under pressure.*

Evidence: Monthly pharmacist review record

2. Are identified irregularities specifically reported to the attending physician, medical director, and director of nursing? — *Specific, documented reporting to the right people, not an informal or incomplete*

escalation.

Evidence: Irregularity reporting record

3. Is there real evidence that reported irregularities are actually acted upon, not just noted and filed? — *Genuine action resulting from the report, not a report that produces no real consequence.*

Evidence: Irregularity resolution record

COMMON REASONS FOR A PARTIAL ANSWER

- **Review happens monthly but doesn't consistently cover every category of potential irregularity.** — A review that misses a category of concern provides only partial protection.
- **Reporting happens but response time from the attending physician is inconsistent.** — A report without a prompt, genuine response doesn't provide the real protection this process is meant to ensure.
- **Irregularities are resolved for individual cases but patterns across residents aren't reviewed collectively.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current pharmacist review practice for consistency and completeness.
Week 2	Establish clear reporting pathways to the attending physician, medical director, and director of nursing.
Week 3	Build a tracking process confirming irregularities lead to genuine action.
Ongoing	Review irregularity patterns across residents for systemic issues.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Monthly review record check	Reviews pharmacist review records for consistent, complete monthly coverage of every resident.
DOCUMENT	Irregularity reporting review	Reviews evidence that identified irregularities are specifically reported to the correct individuals.

Method	What	Detail
ASK	Resolution outcome interview	Asks staff for a real example of an irregularity that was identified and what actually happened as a result.

SUPERVISOR TIPS

- **Ask for a real, recent example of an irregularity and trace it through to its actual resolution.** — A real, traced example reveals whether the process genuinely functions, not just exists on paper.
- **Ask the attending physician how quickly they typically respond to a pharmacist-identified irregularity.** — A specific, confident answer reveals genuine, prompt engagement with the process.

EVIDENCE BASE

[16] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require regular licensed pharmacist review of each resident's complete drug regimen, with identified irregularities reported to the attending physician, medical director, and director of nursing, and acted upon.

[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.

Psychotropic Medications Require a Documented, 4.2 Specific Diagnosis, Not General Behavior Management

NON-NEGOTIABLE

A resident is never started on a psychotropic medication without a specific, diagnosed, clinically documented condition justifying its use — never as a general response to behavior, agitation, or the convenience of managing a resident who is difficult to care for.

In plain terms: No resident is started on an antipsychotic, sedative, or other psychotropic without a specific diagnosed condition that justifies it — 'agitation' or

'behaviour' is not a diagnosis.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Antipsychotics in dementia increase death by about 60%. They cause strokes, falls, and pneumonia. They do not treat dementia; they sedate the person so staff are less troubled. For decades they were prescribed for 'agitation' — a description of behaviour, not a diagnosis. The standard is now clear: a psychotropic requires a documented psychiatric diagnosis for which the drug is indicated (schizophrenia, bipolar disorder, major depression, specified psychosis), the diagnosis must be made by an appropriate clinician, and the prescription must be reviewed. 'Behaviour management' is not an indication; it is a confession that the resident's needs are not being met.

WHAT GOOD LOOKS LIKE

- Every psychotropic medication is tied to a specific, documented diagnosis.
- Non-pharmacological approaches are genuinely tried first.
- Staff can describe the specific condition behind a resident's medication.

COMMON FAILURE MODES

- Psychotropic medication is used as a general response to behavior or agitation.
- No genuine attempt at non-pharmacological approaches precedes medication.
- Staff describe the medication's purpose only in general behavioral terms.

WORKED EXAMPLE

IN PRACTICE

A 60-bed dementia care unit where 45% of residents were on an antipsychotic.

BEFORE	Antipsychotics were started when residents were 'agitated' or 'resistive.' The indication in the record was 'behaviour' or 'dementia with agitation.' No psychiatric diagnosis. Physicians prescribed on staff request. The unit's antipsychotic rate was more than double the national benchmark.
ACTION	A psychotropic prescribing policy was written: no new psychotropic without a specific diagnosis documented by a physician or psychiatrist, with the target symptoms specified; a behavioural assessment (5.1) required first; pharmacist review of every existing psychotropic for indication; a plan to taper any without a valid diagnosis (4.3). The medical director reviewed every antipsychotic prescription over three months.
AFTER	The Monitor reviewed 30 psychotropic prescriptions: all with a documented specific diagnosis or a taper plan. Antipsychotic rate down from 45% to 18% in nine months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every resident on an antipsychotic. For each, what is the diagnosis in the record?
2. If the indication is 'agitation,' 'behaviour,' or 'dementia' alone, that is not a diagnosis.
3. Write the policy: specific diagnosis required, behavioural assessment first.
4. Review every existing prescription.

The most common mistake: Accepting 'dementia with agitation' as a diagnosis — it is a description of a distressed person whose needs are unmet.

SELF-ASSESSMENT QUESTIONS

1. Is every psychotropic medication tied to a specific, diagnosed condition documented in the clinical record? — *A specific,*

documented diagnosis, not a general behavioral rationale.

Evidence: Psychotropic medication diagnosis documentation

2. Are non-pharmacological, behavioral approaches genuinely tried first, before psychotropic medication is started? — *Real, attempted alternatives, not psychotropic medication as the default first response.*

Evidence: Behavioral intervention documentation

3. Can staff describe the specific diagnosed condition behind a particular resident's psychotropic medication? — *Specific, genuine knowledge, not a general sense that the medication helps with behavior.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **New psychotropic orders have specific documented diagnoses but older, long-standing orders lack the same clarity.** — Every psychotropic medication deserves the same documented justification, regardless of when it was originally started.
- **Behavioral approaches are documented as considered but the actual attempt isn't clearly described.** — Considering an alternative isn't the same as genuinely attempting it before resorting to medication.
- **Diagnosis documentation exists but isn't consistently reviewed for continued accuracy over time.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current psychotropic medication orders for specific, documented diagnostic justification.
Week 2	Establish or strengthen non-pharmacological intervention practice and documentation.
Week 3	Train staff on the specific diagnosed conditions behind each resident's psychotropic medications.
Ongoing	Review long-standing psychotropic orders for continued diagnostic accuracy.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Diagnosis documentation review	Reviews psychotropic medication orders for a specific, documented diagnosed condition, not general behavior rationale.
DOCUMENT	Behavioral intervention review	Reviews documentation of non-pharmacological approaches genuinely attempted before medication initiation.
ASK	Staff knowledge interview	Asks staff to describe the specific diagnosed condition behind a particular resident's psychotropic medication.

SUPERVISOR TIPS

- **Ask about a specific, long-standing psychotropic order, not only recently started ones.** — This is where documentation most commonly grows stale or unclear over time.
- **Ask a front-line staff member, not only a nurse, what the medication is specifically for.** — This reveals whether specific understanding genuinely extends through the care team.

EVIDENCE BASE

[17] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit psychotropic drug use unless necessary to treat a specific condition that is diagnosed and documented in the resident's clinical 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.

4.3 Gradual Dose Reduction Is Genuinely Attempted for Psychotropic Medications

NON-NEGOTIABLE

Residents on psychotropic medication receive genuine, documented gradual dose reduction attempts combined with behavioral interventions, unless a specific clinical reason makes this genuinely contraindicated — not medication continued indefinitely without any real attempt to reduce or discontinue it.

In plain terms: For residents on psychotropics, the home genuinely tries to reduce the dose — gradually, with behavioural support, documented — unless a doctor records a specific reason why not.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Once started, psychotropics are rarely stopped. The resident who was sedated during a crisis two years ago is still sedated. Gradual dose reduction — reducing by a step, watching, reducing again, with behavioural interventions in place — is how residents are freed from drugs they no longer need. It must be genuine: a documented attempt, not a note saying 'GDR considered.' It must be gradual: abrupt withdrawal causes rebound. It must be supported: behavioural approaches replace the drug. And if the physician judges a reduction unsafe, the reason must be specific and documented — 'clinically contraindicated' without explanation is not a reason.

WHAT GOOD LOOKS LIKE

- Every resident on psychotropic medication has a genuine, documented reduction attempt.
- Contraindication, where determined, is backed by specific documented clinical reasoning.
- Behavioral interventions are genuinely combined with reduction attempts.

COMMON FAILURE MODES

- Medication continues indefinitely with no documented reduction attempt.
- Contraindication is assumed or undocumented, without real clinical basis.
- Dose reduction, if attempted, happens without any behavioral intervention alongside it.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home where psychotropics, once started, were continued indefinitely.

BEFORE

No dose reduction had been attempted for any resident in living memory. The record said 'GDR not indicated' for most, with no reason. A resident had been on haloperidol for four years following a single episode of agitation after a hospital admission.

ACTION

A GDR protocol was implemented: every resident on a psychotropic has a reduction attempt within three months of the review, then at least twice in the first year, unless the physician documents a specific clinical reason; reductions are stepwise (typically 25% per 2–4 weeks) with behavioural support and monitoring; outcomes are recorded. The pharmacist tracks all residents' GDR status. The haloperidol patient was tapered off over six weeks without incident.

AFTER

The Monitor reviewed 25 psychotropic records: all had documented GDR attempts or specific physician reasons; 14 residents had been successfully reduced or discontinued. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every resident on a psychotropic and the start date.
2. For each, when was a dose reduction last attempted?
3. Start with the resident who has been on the drug longest with the least clear indication.
4. Reduce by a step, watch for four weeks, document.

The most common mistake: Writing 'GDR not indicated' without a reason — that is a decision not to try.

SELF-ASSESSMENT QUESTIONS

1. Does every resident on psychotropic medication have a genuine, documented gradual dose reduction attempt? — *A real, documented attempt, not medication continued indefinitely by default.*

Evidence: Gradual dose reduction documentation

2. Where gradual dose reduction is considered clinically contraindicated, is the specific clinical reason documented? — *A specific, documented clinical justification, not contraindication assumed without real basis.*

Evidence: Contraindication documentation

3. Are behavioral interventions combined with dose reduction attempts, not medication reduction alone? — *Genuine combined approach, not dose reduction attempted in isolation.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Reduction attempts happen for some residents but not consistently across the full population on psychotropic medication.** — Every resident on this medication deserves the same genuine, periodic reconsideration.
- **Contraindication documentation exists but doesn't specifically address why this particular resident's situation warrants it.** — A generic contraindication rationale doesn't reflect the genuine, individual clinical judgement this requires.
- **Reduction is attempted but not systematically tracked to know whether it was ultimately successful.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current psychotropic medication population for documented reduction attempts.
Week 2	Establish a systematic process for periodic dose reduction consideration.
Week 3	Build genuine behavioral intervention practice alongside reduction attempts.
Ongoing	Track reduction attempt outcomes to inform future practice.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Dose reduction attempt review	Reviews documentation of genuine, attempted gradual dose reduction for residents on psychotropic medication.
DOCUMENT	Contraindication justification review	Reviews the specific, documented clinical reasoning behind any contraindication determination.
ASK	Combined approach interview	Asks staff whether behavioral interventions are genuinely combined with dose reduction attempts.

SUPERVISOR TIPS

- **Ask for a specific resident's dose reduction history over the past year.** — A real, traceable history reveals whether reduction is genuinely attempted, not just theoretically required.
- **Ask what behavioral intervention accompanied a specific reduction attempt.** — A specific, real answer reveals genuine combined practice, not medication-only reduction.

EVIDENCE BASE

[18] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require residents using psychotropic drugs to receive gradual dose reduction and behavioral interventions, unless clinically contraindicated, in a genuine effort to discontinue these drugs.

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.

4.4 PRN Psychotropic Orders Are Time-Limited and Re-Evaluated, Not Renewed Automatically

NON-NEGOTIABLE

As-needed psychotropic medication orders are limited to 14 days, with antipsychotic PRN orders specifically requiring a physician re-evaluation before any renewal — not extended or renewed automatically as a matter of routine.

In plain terms: As-needed psychotropic orders expire after 14 days; PRN antipsychotics need a doctor's face-to-face review to continue — they are never auto-renewed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A PRN sedative order written 'for agitation' with no expiry becomes a standing permission to sedate at staff discretion, indefinitely. The resident is given lorazepam whenever a shift is short-staffed. The 14-day limit forces a review: is the drug still needed? Is it being used appropriately? What is the pattern? For antipsychotics, the review must be by a physician who has seen the resident — not a phone renewal. The rule is deliberately inconvenient; convenience is how PRN psychotropics become chemical restraint.

WHAT GOOD LOOKS LIKE

- PRN psychotropic orders are genuinely limited to 14 days.
- Antipsychotic PRN renewal requires a real, documented physician re-evaluation.
- Any extension beyond 14 days carries specific, documented clinical rationale.

COMMON FAILURE MODES

- PRN orders are routinely extended or renewed without genuine time limits.
- Antipsychotic renewal happens without real re-evaluation.
- Extensions lack specific clinical rationale.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home where PRN lorazepam orders had no expiry.

BEFORE	PRN psychotropic orders were written once and used for months or years. The Coordinator found a resident whose PRN lorazepam order was three years old and had been used 140 times in the previous six months, almost always on night shift. No review had occurred.
ACTION	The medication system was configured to expire all PRN psychotropic orders at 14 days. Renewal requires a physician review; for antipsychotics, a documented face-to-face assessment. The nurse manager reviews PRN administration patterns weekly — frequency, shift, staff member — and any pattern suggesting convenience use is escalated. Behavioural alternatives are documented before each PRN dose.
AFTER	The Monitor reviewed the PRN order register (all current orders under 14 days or renewed with documented review), the weekly administration pattern reports, and PRN psychotropic use down 70%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every PRN psychotropic order and its date. Any over 14 days is out of compliance.
2. Configure the system to expire PRN psychotropics at 14 days.
3. Require face-to-face physician review for PRN antipsychotic renewal.
4. Review PRN use patterns weekly by shift.

The most common mistake: PRN orders that renew automatically — an open-ended PRN sedative is a licence for chemical restraint.

SELF-ASSESSMENT QUESTIONS

1. Are all PRN psychotropic orders genuinely limited to 14 days, not extended automatically? — *A genuine, enforced 14-day limit, not a routine extension.*

Evidence: PRN order duration record

2. Does any PRN antipsychotic renewal require a genuine physician re-evaluation, not automatic continuation? — *A real, documented re-evaluation specifically for antipsychotics, not a rubber-stamp renewal.*

Evidence: Antipsychotic renewal re-evaluation documentation

3. Where a PRN order is extended beyond 14 days for a non-antipsychotic, is the physician's rationale specifically documented? — *A specific, documented clinical rationale, not an extension without real justification.*

Evidence: Extension rationale documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **The 14-day limit is tracked for most orders but occasionally lapses during staff transitions.** — Consistent tracking regardless of staffing changes is what makes this limit genuinely reliable.
- **Re-evaluation happens for antipsychotic renewals but isn't always documented with specific clinical detail.** — Undocumented re-evaluation is difficult to distinguish from renewal without genuine reconsideration.
- **Extension rationale is documented but sometimes generic rather than specific to the individual resident's situation.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current PRN psychotropic order tracking for genuine 14-day limit enforcement.
Week 2	Establish a specific re-evaluation process required before any antipsychotic PRN renewal.
Week 3	Train prescribing staff on documentation requirements for any extension beyond 14 days.
Ongoing	Audit PRN order duration and renewal documentation for continued compliance.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	PRN order duration review	Reviews PRN psychotropic order records for genuine 14-day limit enforcement.

Method	What	Detail
DOCUMENT	Antipsychotic re-evaluation review	Reviews documentation of genuine physician re-evaluation before any antipsychotic PRN renewal.
ASK	Renewal practice interview	Asks prescribing staff how PRN psychotropic renewal genuinely works in practice.

SUPERVISOR TIPS

- **Ask for a specific, real example of an antipsychotic PRN renewal and its re-evaluation documentation.** — A real, traceable example reveals whether re-evaluation is genuine practice, not a formality.
- **Check PRN order tracking during a period of staff transition or turnover.** — This is where consistent enforcement of the time limit is most likely to lapse.

EVIDENCE BASE

[19] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, limit as-needed psychotropic orders to a short, defined duration, with as-needed antipsychotic orders specifically prohibited from renewal unless the attending physician or prescribing practitioner evaluates the resident for continued appropriateness.

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.

4.5 Infection Control Follows a Defined, Facility-Specific Program

NON-NEGOTIABLE

The facility maintains an infection prevention and control program specific to its own resident population and physical environment, with a designated, trained infection preventionist — not a generic infection control policy

adopted without genuine adaptation to this facility's actual circumstances.

In plain terms: The home has an infection prevention programme written for its own residents and building — surveillance, outbreak plan, antibiotic stewardship, staff training — not a generic policy copied from a hospital.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Care homes are where outbreaks kill: influenza, norovirus, COVID-19, and antibiotic-resistant organisms spread through shared dining rooms, shared staff, and residents who cannot isolate. A hospital infection control policy does not fit: care homes have no isolation rooms, residents wander, and the goal is a home, not a ward. A facility-specific programme addresses: surveillance (which infections, how counted), outbreak recognition and response (when to close, when to notify, how to cohort), antibiotic stewardship (the majority of care home antibiotics are unnecessary and drive resistance), immunisation of residents and staff, hand hygiene, environmental cleaning, and a named infection control lead with training.

WHAT GOOD LOOKS LIKE

- The infection control program genuinely reflects this facility's specific population and environment.
- A designated, trained infection preventionist holds real responsibility for the program.
- The program is genuinely reviewed and updated, not static.

COMMON FAILURE MODES

- A generic infection control policy is adopted without facility-specific adaptation.
- No specific, trained individual holds genuine responsibility for infection control.
- The program hasn't been reviewed or updated in a meaningful timeframe.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home with an infection control policy adapted from a hospital.

BEFORE	The policy referenced isolation rooms the home did not have. No surveillance; infections were treated as they arose. A norovirus outbreak the previous year affected 40 residents and 15 staff before anyone recognised it. Antibiotics were prescribed for every positive urine dipstick. No infection control lead.
ACTION	A care-home-specific programme was written with the regional infection control team: monthly surveillance of respiratory, GI, urinary, and skin infections; an outbreak plan with triggers (two similar cases in 48 hours), actions (cohorting, enhanced cleaning, visitor guidance, notification); an antibiotic stewardship protocol (no treatment of asymptomatic bacteriuria; McGeer criteria for infection); annual influenza vaccination for residents and staff with tracked uptake; a trained infection control lead; quarterly hand hygiene audit.
AFTER	The Monitor reviewed the programme, six months of surveillance data, the outbreak plan, antibiotic prescribing data (urinary antibiotics down 55%), and staff influenza uptake (72%). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your infection control policy. Does it describe your building, or a hospital?
2. Name an infection control lead and get them trained.
3. Start monthly surveillance of the four infection types.
4. Write an outbreak plan with clear triggers.

The most common mistake: Treating every positive urine dipstick with antibiotics — most care home residents have bacteria in their urine and no infection.

SELF-ASSESSMENT QUESTIONS

1. Does the infection control program genuinely reflect this facility's own resident population and physical environment? — *Facility-specific adaptation, not a generic policy adopted without genuine customization.*

Evidence: Infection control program documentation

2. Is there a designated, trained infection preventionist with genuine responsibility for the program? — *A specific, trained, designated individual, not an informal or shared responsibility.*

Evidence: Infection preventionist designation and training record

3. Is the program genuinely reviewed and updated based on the facility's own actual assessment, not left static? — *Real, ongoing adaptation, not a program written once and never revisited.*

Evidence: Program review and update record

COMMON REASONS FOR A PARTIAL ANSWER

- **An infection preventionist is designated but their specific training doesn't fully meet defined requirements.** — The role's real protective value depends on genuine, adequate training, not designation alone.
- **The program addresses common infection risks but doesn't specifically reflect this facility's particular resident population.** — Generic coverage of common risks can still miss what's specifically relevant to this facility's actual circumstances.
- **Program review happens but doesn't consistently incorporate genuinely current facility assessment data.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current infection control program for genuine facility-specific adaptation.
Week 2	Confirm or establish infection preventionist designation and training against defined requirements.
Week 3	Establish a genuine, scheduled program review process incorporating current facility assessment.
Ongoing	Update the infection control program as facility circumstances genuinely change.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Program specificity review	Reviews the infection control program for genuine, facility-specific content, not generic policy.
DOCUMENT	Infection preventionist designation review	Reviews the designation and training of the facility's infection preventionist.
DOCUMENT	Program update review	Reviews evidence that the program is genuinely reviewed and updated based on facility assessment.

SUPERVISOR TIPS

- **Ask the infection preventionist to describe a specific risk factor unique to this facility's population.** — A specific, informed answer reveals genuine facility-specific engagement, not a generic role.
- **Ask when the program was last genuinely reviewed and what changed as a result.** — A specific, real answer reveals whether review is genuine practice, not just a stated requirement.

EVIDENCE BASE

[20] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require facilities to establish and maintain an infection prevention and control program based on the facility's own assessment, with a designated infection preventionist holding specific training.

[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.

← **Long-Term Care Standards — all standards**

Self-assess against these criteria →

← **Standard 3 — Personal Care & Daily Living**

**Standard 5 — Cognitive &
Behavioral Care →**

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ASF STANDARDS · LONG-TERM CARE · STANDARD 5

Standard 5 — Cognitive & Behavioral Care

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 5.1 — Behavioral Expressions Are Understood as Communication, Not Managed as Problems
- 5.2 — Wandering Risk Is Assessed Using a Validated Tool, Not Informal Judgment
- 5.3 — Elopement Prevention Balances Genuine Safety With Resident Autonomy
- 5.4 — Dementia Care Staff Receive Specific, Ongoing Training, Not General Orientation Alone
- 5.5 — A Resident's Individual Life History Genuinely Shapes Their Care

5.1 Behavioral Expressions Are Understood as Communication, Not Managed as Problems

NON-NEGOTIABLE

Staff are trained to understand behavioral expressions — agitation, resistance to care, repetitive movement — as genuine communication of an unmet need or distress, with a specific process to identify and address the underlying cause, not a default response aimed only at stopping the behavior itself.

In plain terms: When a resident with dementia is agitated, resists care, or calls out, staff ask 'what are they telling us?' — pain, fear, a need — rather than 'how do we stop this?'

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A person with dementia who cannot say 'my hip hurts' hits the care worker who tries to move them. A person who cannot say 'I need the toilet' becomes agitated and wanders. A person who cannot say 'I'm frightened of this stranger undressing me' screams. Behaviour is communication when words fail. Staff who understand this look for the cause — pain, hunger, toileting, fear, boredom, overstimulation — and address it; staff who see behaviour as a problem reach for a sedative. Training in person-centred dementia care changes the question, and changing the question changes the outcome.

WHAT GOOD LOOKS LIKE

- Staff genuinely understand and describe behavioral expressions as communication.
- A structured process identifies the underlying cause behind each expression.
- Responses address the genuine underlying need, not just the visible behavior.

COMMON FAILURE MODES

- Staff describe behaviors only as problems to manage or stop.
- No structured process exists to identify underlying causes.
- Responses aim only to suppress the visible behavior, regardless of its cause.

WORKED EXAMPLE

IN PRACTICE

A 40-bed dementia unit with high rates of 'challenging behaviour' and PRN sedation.

BEFORE

Behaviour was recorded as 'aggressive,' 'resistive,' 'agitated.' The response was PRN medication or leaving the resident alone. A

	resident who hit staff during morning care was sedated for months; a physiotherapy assessment eventually found a painful frozen shoulder that care had been aggravating. No behavioural assessment tool was used.
ACTION	Staff completed a person-centred dementia care programme. A behavioural assessment tool (e.g. the ABC chart or a validated unmet-needs framework) is completed for any distressed behaviour: what happened before, what the behaviour was, what happened after, and what need it might express. Pain is assessed with a dementia-specific scale (PAINAD) first. Care plans include known triggers and effective responses. Weekly team reviews discuss each resident with distress.
AFTER	The Monitor reviewed 20 behavioural assessments with identified needs and care plan changes, PAINAD use in all, and PRN sedation down 65%. Interviewed a care assistant who described finding that a resident's calling out was hunger. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your last ten behaviour incident reports. Do they describe behaviour, or ask why?
2. Train staff in person-centred dementia care.
3. Use a pain scale designed for dementia before anything else.
4. Adopt a behavioural assessment tool and use it every time.

The most common mistake: Describing a resident as 'aggressive' — a person in pain who cannot speak is not aggressive; they are communicating.

SELF-ASSESSMENT QUESTIONS

1. Are staff trained to understand behavioral expressions as communication of an unmet need, not as problems to be stopped?
— *Genuine understanding of behavior as communication, not framed*

only as disruption to manage.

Evidence: Staff training record on behavioral expressions

2. Is there a specific process to identify the underlying cause behind a behavioral expression? — *A real, structured process, not an assumption that the cause is simply the dementia itself.*

Evidence: Behavioral assessment documentation

3. Does the response address the identified underlying need, not only aim to stop the visible behavior? — *A response matched to the genuine cause, not suppression of the behavior alone.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Understanding is strong among nursing staff but less consistently reinforced with support staff who spend significant time with residents.** — Any staff member interacting with a resident benefits from genuinely understanding behavior as communication.
- **Cause identification happens for more disruptive expressions but not consistently for quieter, less visible ones.** — A quieter expression of distress deserves the same genuine attention as a more visible one.
- **The underlying cause is identified but the response doesn't consistently address it directly.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current staff understanding and training on behavioral expressions as communication.
Week 2	Establish a structured underlying-cause assessment process.
Week 3	Train all staff, including support roles, on cause-directed response.
Ongoing	Review behavioral response practice using real, recent examples.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Staff training review	Reviews training content for genuine coverage of behavioral expressions as communication.

Method	What	Detail
DOCUMENT	Underlying cause assessment review	Reviews documentation for a structured process identifying the cause behind behavioral expressions.
OBSERVE	Response practice observation	Observes an actual staff response to a behavioral expression for genuine cause-directed care.

SUPERVISOR TIPS

- **Ask a staff member to describe a recent behavioral expression and what they believe was actually driving it.** — A specific, thoughtful answer reveals genuine understanding, not a memorized framework.
- **Ask a support staff member, not only nursing staff, about their understanding of behavioral expressions.** — This reveals whether the approach genuinely extends beyond clinical staff.

EVIDENCE BASE

[21] Cohen-Mansfield J. The Unmet Needs Framework for understanding behavioral expressions in dementia, as applied in current long-term care practice, identifies behavior as communication of underlying emotional or physical distress rather than pathology to be suppressed, requiring identification and response to the genuine underlying need.

[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.

5.2 Wandering Risk Is Assessed Using a Validated Tool, Not Informal Judgment

NON-NEGOTIABLE

Every resident with cognitive impairment is assessed for wandering and elopement risk using a validated, structured tool, at admission and after any significant change — not an informal, subjective judgement about which residents seem likely to wander.

In plain terms: Every resident with cognitive impairment is assessed for the risk of wandering away with a validated tool — at admission and after any change — not by staff impression.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A resident with dementia who walks out of an unlocked door on a winter night dies of exposure within hours. Elopement is rare, predictable, and fatal. The residents at risk are identifiable: those with a history of wandering, those who express a desire to leave, those who are physically mobile and cognitively impaired, those who are newly admitted and disoriented. A validated tool assesses these systematically; staff impression misses the quiet resident who has never tried to leave until the day she does. The assessment must be repeated: a resident who was not at risk becomes at risk when their dementia progresses or their spouse dies.

WHAT GOOD LOOKS LIKE

- Every resident with cognitive impairment receives a validated, structured wandering risk assessment.
- Reassessment genuinely happens after significant condition changes.
- Assessment results specifically inform the individual care plan.

COMMON FAILURE MODES

- Wandering risk is judged informally, without a structured, validated tool.
- Assessment happens only once, never updated as the resident's condition changes.
- Assessment results are recorded but don't inform the actual care plan.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home with a secure dementia wing and an open general wing.

BEFORE

Wandering risk was judged by whether a resident had 'tried to leave.' No tool. A resident on the open wing with early dementia and no prior

	wandering walked out during a shift change and was found four hours later by police, hypothermic. Her cognitive decline over the previous two months had not triggered a reassessment.
ACTION	A validated elopement risk tool was adopted for every resident with cognitive impairment at admission, quarterly, and after any change (new diagnosis, medication change, bereavement, move). Risk level is recorded on the care plan and the shift handover. Residents at moderate or high risk have specific measures (5.3). Staff were trained to recognise the signs of escalating risk between assessments.
AFTER	The Monitor reviewed 30 assessments for cognitively impaired residents with risk levels and reassessment dates; two showed risk escalation after cognitive decline with measures updated. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every resident with cognitive impairment. Which have a documented wandering risk assessment?
2. Adopt a validated tool.
3. Assess everyone with cognitive impairment now, and quarterly.
4. Put the risk level on the handover sheet.

The most common mistake: Assessing wandering risk only for residents who have already wandered.

SELF-ASSESSMENT QUESTIONS

1. Is every resident with cognitive impairment assessed for wandering risk using a validated, structured tool? — *A specific, validated assessment, not an informal staff impression.*

Evidence: Wandering risk assessment record

2. Is the assessment repeated after any significant change in the resident's cognitive or physical condition? — *Genuine reassessment*

reflecting the resident's current, actual risk, not a one-time evaluation.

Evidence: Reassessment record

3. Does the assessment result specifically inform the resident's individual care plan? — *Genuine, individual application of the assessment, not a result recorded without practical use.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Assessment happens at admission but reassessment after a cognitive decline isn't consistently triggered.** — Wandering risk can change significantly as cognitive impairment progresses.
- **The tool is used but not consistently by all staff conducting assessments.** — Consistent, correct use across all assessing staff is what makes a validated tool genuinely reliable.
- **Assessment results are documented but the care plan doesn't specifically reflect identified risk factors.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current wandering risk assessment practice for validated tool use versus informal judgement.
Week 2	Train staff on consistent, correct administration of the validated assessment tool.
Week 3	Establish a specific reassessment trigger tied to significant condition changes.
Ongoing	Confirm assessment results are genuinely reflected in individual care plans.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Assessment tool review	Reviews the specific, validated tool used for wandering risk assessment.
DOCUMENT	Reassessment record review	Reviews evidence that assessment is repeated after significant condition changes.
DOCUMENT	Care plan application review	Reviews whether assessment results specifically inform the individual care plan.

SUPERVISOR TIPS

- **Ask to see the actual validated assessment tool used, not a general description of risk judgement.** — A specific, named tool is the real evidence of structured, validated practice.
- **Ask how a specific resident's wandering risk assessment translated into their actual care plan.** — A specific, real example reveals genuine application, not assessment for its own sake.

EVIDENCE BASE

[22] Algase DL, Beattie ERA, Antonakos C, Beel-Bates CA, Yao L. Wandering and the physical environment. Am J Alzheimers Dis Other Demen. 2010 — establishes structured, validated wandering risk assessment, including the Algase Wandering Scale, as the standard for identifying elopement and wandering risk in long-term care, distinct from informal staff judgement.

[**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.

5.3 **Elopement Prevention Balances Genuine Safety With Resident Autonomy**

NON-NEGOTIABLE

Elopement prevention measures are individualized and proportionate to actual assessed risk, genuinely balancing safety with the resident's autonomy and freedom of movement — not a blanket, facility-wide restriction, such as a locked unit, applied to every resident regardless of individual risk or need.

In plain terms: Measures to stop residents leaving are matched to each person's actual risk — a door alarm, a wristband, supervised walks — not a locked unit for everyone, and not nothing until someone gets out.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

The two failures are opposite: locking every resident with dementia in a secure unit regardless of risk (which imprisons people who would never wander and removes their freedom to walk in a garden), and leaving the door open until someone dies (which is negligence).

Proportionate means: the low-risk resident has freedom of movement; the moderate-risk resident has a wristband alarm and staff awareness; the high-risk resident has door alarms, a secure area, and supervised outdoor time. The balance is documented, reviewed, and — critically — the resident's autonomy is preserved as far as safety allows.

Freedom to walk is a right; it is restricted only as much as necessary.

WHAT GOOD LOOKS LIKE

- Elopement prevention is genuinely individualized to actual assessed risk.
- Lower-risk residents retain genuine freedom of movement.
- Any restrictive measure carries specific, individual documented justification.

COMMON FAILURE MODES

- A blanket, facility-wide restriction is applied regardless of individual risk.
- All residents face the same restriction regardless of their actual assessed risk level.
- Restrictive measures lack specific, individual justification.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home with a locked dementia unit for all residents with any cognitive impairment.

BEFORE

Any resident with a dementia diagnosis was placed in the locked unit. Many had no wandering risk. They could not access the garden or the main lounge. Families complained their relative was 'imprisoned.' Meanwhile, a resident in the open wing with undocumented wandering risk left the building twice.

ACTION

Elopement risk was assessed for all (5.2). Measures were individualised: low-risk residents moved to the open wing with garden access; moderate-risk residents received wristband

alarms at exits and are checked hourly; high-risk residents have the secure unit with a secure garden and daily supervised walks outside it. A monthly review reconsiders each resident's level. Door alarms were fitted on all exits; the response protocol is tested monthly.

AFTER

The Monitor reviewed the risk register with individualised measures, observed low-risk residents in the garden, tested a door alarm, and reviewed two monthly level reviews. No elopements in six months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List who is in your secure unit and why. For each, what is their assessed risk?
2. Match measures to risk levels: freedom, alarm, secure.
3. Give every resident, including high-risk, supervised outdoor time daily.
4. Review levels monthly.

The most common mistake: Locking the unit for everyone — safety that removes freedom from people who were never at risk is not safety, it is convenience.

SELF-ASSESSMENT QUESTIONS

1. Are elopement prevention measures individualized to the resident's actual assessed risk, not applied as a blanket facility-wide restriction? — *Genuine individualization matched to real risk, not uniform restriction regardless of individual need.*

Evidence: Individualized elopement prevention plan

2. Do residents with lower assessed risk retain genuine freedom of movement, not restricted by default? — *Real, preserved autonomy for lower-risk residents, not restriction applied to everyone regardless of risk level.*

Evidence: N/A — tested directly

3. Is there a specific, documented justification when a more restrictive measure is genuinely used for a specific resident? —

Specific, individual justification, not a default facility-wide policy.

Evidence: Restrictive measure justification documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Individualization is genuine for the physical environment but less so for daily activity scheduling.** — Autonomy and safety balance extends beyond physical space alone to how a resident's day is genuinely structured.
- **Lower-risk residents have some freedom but staff practice is inconsistent in genuinely respecting it.** — A policy of preserved autonomy needs consistent staff practice to provide real protection of resident freedom.
- **Restrictive measures are individually justified initially but not periodically reconsidered as risk changes.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current elopement prevention practice for genuine individualization versus blanket restriction.
Week 2	Establish individualized prevention plans matched to actual assessed risk.
Week 3	Train staff on genuinely preserving autonomy for lower-risk residents.
Ongoing	Periodically reconsider restrictive measures as individual risk genuinely changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Individualization review	Reviews elopement prevention plans for genuine individual tailoring to assessed risk.
OBSERVE	Autonomy preservation observation	Observes whether lower-risk residents genuinely retain freedom of movement.
DOCUMENT	Restrictive measure justification review	Reviews specific, individual documented justification for any more restrictive measure used.

SUPERVISOR TIPS

- **Ask to see elopement prevention plans for two different residents with different risk levels.** — Genuinely different plans reveal real individualization; identical plans reveal a blanket approach.
- **Ask a lower-risk resident or their family about their actual freedom of movement in daily practice.** — This tests lived experience, not just policy intent.

EVIDENCE BASE

[23] Individualized, proportionate elopement prevention measures, balanced against resident autonomy and freedom of movement, are established practice in long-term care dementia management, distinct from blanket facility-wide restriction applied without individual justification.

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.

5.4 **Dementia Care Staff Receive Specific, Ongoing Training, Not General Orientation Alone**

NON-NEGOTIABLE

Staff providing direct care to residents with dementia receive specific, ongoing dementia care training — communication techniques, behavioral expression response, person-centered approach — not a single general orientation session treated as sufficient for the duration of their employment.

In plain terms: Staff caring for residents with dementia get specific, ongoing dementia training — communication, understanding behaviour, personal care techniques — not just a general orientation on day one.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

Dementia care is a skill. Knowing how to approach a person from the front and at eye level, how to offer one choice at a time, how to redirect rather than argue, how to bathe someone who is frightened of water, how to recognise pain in someone who cannot report it — none of this is intuitive, and all of it can be taught. Staff without training use force, restraint, and sedation because they have nothing else. Ongoing means: initial training before working with residents with dementia, annual refresher, and topic sessions through the year. A general orientation that mentions dementia for 20 minutes does not qualify anyone.

WHAT GOOD LOOKS LIKE

- Staff receive specific, dementia-focused training distinct from general orientation.
- Training is genuinely ongoing and recurring, not a single session.
- Staff can demonstrate specific, genuine dementia care skills.

COMMON FAILURE MODES

- Dementia care content is folded into general orientation with no specific focus.
- Training happens once and is never repeated or reinforced.
- Staff can describe general awareness but cannot demonstrate specific skills.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home where dementia care was part of general orientation.

BEFORE

New staff received a two-hour orientation covering the home's policies, with a slide on dementia. Care assistants with no dementia training were assigned to the dementia unit on day one. Turnover on the unit was high; staff described it as 'the hard unit.' Resident distress and staff injuries were common.

ACTION

A dementia care training programme was implemented: a recognised 8-hour foundation course for all staff before working with residents with dementia; an annual 4-hour refresher;

monthly one-hour topic sessions (communication, personal care, pain, end-stage dementia, family support); on-unit coaching by a trained lead. Training records are tracked per staff member. Agency staff are given a one-hour briefing before their first shift.

AFTER

The Monitor reviewed training records (98% of dementia unit staff with foundation training), the topic session calendar and attendance, and interviewed three care assistants who described specific techniques they used. Staff injuries down 60%; turnover on the unit halved. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three care assistants on the dementia unit what dementia training they have had.
2. Adopt a recognised foundation course and require it before dementia unit work.
3. Schedule monthly topic sessions.
4. Track training per person.

The most common mistake: Calling a slide in general orientation 'dementia training.'

SELF-ASSESSMENT QUESTIONS

1. Do staff providing direct dementia care receive specific training beyond general orientation? — *Specific, dementia-focused training content, not folded into general orientation alone.*

Evidence: Dementia-specific training record

2. Is this training genuinely ongoing, not a single session treated as sufficient indefinitely? — *Real, recurring training, not a one-time requirement.*

Evidence: Ongoing training schedule

3. Can staff demonstrate specific dementia care skills — communication technique, behavioral response — not just describe general awareness? — *Genuine, demonstrable skill, not familiarity with the concept alone.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Initial training is specific and thorough but ongoing reinforcement is inconsistent.** — Skill retention and development genuinely benefit from recurring reinforcement, not a strong single session alone.
- **Nursing staff receive specific training but support and ancillary staff receive less.** — Any staff member interacting with residents benefits from genuine dementia care skill, not clinical staff alone.
- **Training covers communication technique well but behavioral expression response less thoroughly.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current dementia care training for specificity versus general orientation content.
Week 2	Build or strengthen specific training content covering communication and behavioral response.
Week 3	Establish a recurring training schedule reaching all staff who interact with residents.
Ongoing	Assess staff skill demonstration periodically, not just training completion.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Training content review	Reviews training content for specific dementia care focus, not general orientation alone.
DOCUMENT	Ongoing training schedule review	Reviews the schedule and actual delivery of recurring dementia care training.
OBSERVE	Skill demonstration observation	Observes staff demonstrating specific dementia care communication and response skills.

SUPERVISOR TIPS

- **Ask a support staff member, not only nursing staff, about their dementia care training.** — This reveals whether specific training genuinely reaches everyone who interacts with residents.
- **Ask staff to demonstrate, not just describe, a specific communication technique.** — Demonstration reveals genuine skill,

not just familiarity with training content.

EVIDENCE BASE

[24] Tilly J, Reed P. Dementia Care Practice Recommendations for Assisted Living and Nursing Homes. Chicago: Alzheimer's Association — establishes specific, ongoing dementia care training, including communication techniques and person-centered approach, as distinct from general staff orientation, as a core practice recommendation for long-term care.

[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.

5.5 **A Resident's Individual Life History** CORE **Genuinely Shapes Their Care**

Each resident's individual life history — career, family, meaningful roles, personal preferences — is genuinely gathered and actively used to shape their daily care and activity engagement, not collected once as an intake formality and never referenced again.

In plain terms: Each resident's life story — what they did, who they loved, what mattered to them — is gathered from them and their family and actually used in daily care.

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

WHY THIS MATTERS

A resident who was a farmer wakes at 5am and wants to go outside. A resident who was a nurse becomes distressed when others are unwell and calms when 'helping.' A resident who lost a child in wartime is terrified of sirens. None of this is visible without asking. A life story — gathered at admission from the resident and family, recorded in an accessible format, and read by every care worker — transforms care: the farmer gets an early garden walk, the nurse gets a helping role, the siren is explained before the fire alarm test. Without it, staff care for a diagnosis; with it, they care for a person.

WHAT GOOD LOOKS LIKE

- Individual life history is genuinely gathered for every resident.
- Life history information is actively used to shape daily care and activities.
- Staff can describe specific, real examples of life history shaping care.

COMMON FAILURE MODES

- Life history gathering is skipped or minimal.
- Information is collected but never referenced in actual daily care.
- Staff cannot describe any specific example of life history informing care.

WORKED EXAMPLE

IN PRACTICE

A 50-bed dementia care home where staff knew residents' care needs but not their lives.

BEFORE

The record contained medical history and care needs. Nothing about the person. Care workers did not know that Mrs K had been a concert pianist, that Mr L had run a bakery, that Mrs M's husband had died in a fire. Care was competent and impersonal. Residents were 'the lady in room 12.'

ACTION

A life story template was introduced: gathered at admission from the resident and family in a one-hour conversation; covering childhood, work, family, faith, interests, significant events, daily routines, likes and dislikes, and what calms and distresses them. Summarised on one page in each resident's room ('This is me') and in the care plan. Staff read it before their first shift with a resident. Activities and daily routines are built from it. A piano was placed in the lounge; Mrs K plays daily.

AFTER

The Monitor reviewed 20 life stories and matching care plan adaptations, observed the 'This is me' sheets in rooms, and interviewed a care assistant who described three residents' histories and how they shaped her care. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three care workers to tell you something about a resident's life before the home. Note how much they know.
2. Create a one-hour life story conversation at admission.
3. Summarise on one page in each room.
4. Require staff to read it before caring for a resident.

The most common mistake: Knowing a resident's diagnosis and care needs and nothing about who they are.

SELF-ASSESSMENT QUESTIONS

1. Is each resident's individual life history genuinely gathered, not skipped or treated as optional? — *Real, gathered life history information, not an assumption it's unnecessary or too difficult to obtain.*
Evidence: Life history documentation
2. Is this information actively used to shape daily care and activity engagement, not filed away unused? — *Genuine, ongoing use, not information collected once and never referenced.*
Evidence: N/A — tested directly
3. Can staff describe a specific way a resident's life history has genuinely shaped their care approach? — *A specific, real example, not a general statement that life history is considered.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Life history is gathered at admission but not updated as family provides additional information over time.** — A resident's history often emerges gradually through ongoing family relationships, not only at a single intake conversation.
- **Information is used for activity planning but less consistently for understanding behavioral expressions.** — Life history carries real value for interpreting behavior, not only for planning activities.

- **Some staff genuinely use this information but it isn't consistently shared across the full care team.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current life history gathering practice for completeness and genuine depth.
Week 2	Establish a process for life history information to genuinely reach the full care team.
Week 3	Train staff on connecting life history to both activity planning and behavioral understanding.
Ongoing	Update life history documentation as new information emerges through family relationships.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Life history gathering review	Reviews documentation for genuine, gathered individual life history for each resident.
OBSERVE	Care application observation	Observes whether life history information is genuinely reflected in actual daily care and activities.
ASK	Staff example interview	Asks staff for a specific example of a resident's life history shaping their care approach.

SUPERVISOR TIPS

- **Ask a staff member for a specific detail from a resident's life history and how it shapes their approach.** — A specific, real answer reveals genuine use, not documentation for its own sake.
- **Ask a family member whether they feel the facility genuinely knows their relative as an individual.** — This tests lived experience of person-centered care, not documentation completeness alone.

EVIDENCE BASE

[25] Edvardsson D, Winblad B, Sandman PO. Person-centered care of people with severe Alzheimer's disease: current status and ways forward. *Lancet Neurol.* 2008;7(4):362-367 — establishes genuine use of individual life history and personhood, not cognitive status alone, as foundational to effective person-centered dementia care.

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.

← **Long-Term Care
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 4 — Clinical &
Medical Care**

**Standard 6 — End-of-Life &
Palliative Care →**

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