

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

ASF STANDARDS · LONG-TERM CARE · STANDARD 6

Standard 6 — End-of-Life & Palliative Care

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

CRITERIA IN THIS STANDARD

- 6.1 — Advance Directives Are Discussed Proactively, Not Only When a Crisis Arrives
- 6.2 — Palliative Care Is Available Regardless of Terminal Diagnosis
- 6.3 — Hospice Coordination Follows a Real, Written Agreement, Not Informal Handoff
- 6.4 — Pain and Suffering Are Actively Anticipated and Treated, Not Just Responded To
- 6.5 — Family Is Genuinely Included in End-of-Life Decisions, Not Just Informed

6.1 Advance Directives Are Discussed Proactively, Not Only When a Crisis Arrives

NON-NEGOTIABLE

Every resident, or their legal representative, is proactively offered a genuine conversation about advance directives and life-sustaining treatment preferences at admission and periodically thereafter — not first raised during a medical crisis, when there is far less time and far more distress to make a considered decision.

In plain terms: Every resident or their representative is offered a proper conversation about advance directives and treatment wishes — early, calmly, and repeated — not only when a crisis forces the question.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The question 'would she want to be resuscitated?' asked in the ambulance at 3am to a daughter who has never discussed it produces the wrong answer and lifelong guilt. The same conversation held at admission, with time, with the resident participating while they still can, produces a considered decision that honours what the person actually wanted. Proactive means: offered to every resident within the first month, held by someone trained, documented in a way that is accessible at 3am, revisited annually and after any significant change, and — critically — followed. A directive that exists but is not found or not followed is worse than none.

WHAT GOOD LOOKS LIKE

- Every resident or representative receives a genuine, proactive advance directive conversation.
- Preferences are periodically revisited, not captured once and forgotten.
- Documentation is genuinely accessible to staff when actually needed.

COMMON FAILURE MODES

- Advance directives are raised only during a medical crisis, if at all.
- Preferences are captured once at admission and never revisited.
- Documentation exists but isn't practically accessible in a real emergency.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home where advance care planning happened, if at all, in hospital during emergencies.

BEFORE	No advance care planning process. Residents were sent to hospital by default when they deteriorated. Several with advanced dementia had been resuscitated or ventilated against what families later said they would have wanted. Directives that existed were in family homes, not the care home record.
ACTION	An advance care planning process was introduced: a trained nurse offers a conversation within 30 days of admission covering the resident's values, treatment preferences, resuscitation, hospitalisation, and who decides if they cannot; the resident participates as far as able; the outcome is documented on a standard form at the front of the record and flagged on the handover; the conversation is repeated annually and after any significant change; the physician reviews and signs. Emergency transfer protocols check the directive first.
AFTER	The Monitor reviewed 40 resident records: 38 with completed advance care plans, all accessible at the front of the record; two declined and documented. Reviewed three emergency events where the directive was checked and followed. Hospital transfers down 30%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count residents with a documented advance care plan. Below 80% is a gap.
2. Train two nurses in advance care planning conversations.
3. Offer a conversation to every resident within 30 days of admission.
4. Put the outcome at the front of the record and on the handover.

The most common mistake: Waiting for the crisis to ask — the crisis is the worst possible time to ask.

SELF-ASSESSMENT QUESTIONS

1. Is every resident or representative proactively offered a genuine advance directive conversation at admission? — *A real, offered conversation, not paperwork provided without discussion.*

Evidence: Advance directive conversation record

2. Is this conversation revisited periodically, not held once and never referenced again? — *Genuine, periodic revisiting, not a single admission-only conversation.*

Evidence: Periodic review record

3. Are documented preferences genuinely accessible to staff at the moment they're actually needed? — *Real, practical accessibility in a genuine emergency, not a document filed away and hard to locate.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The conversation happens at admission but isn't revisited even after a significant change in the resident's condition.** — A resident's preferences, or their ability to express them, can genuinely change over time.
- **Documentation is thorough but stored in a way that's slow to locate during an actual emergency.** — Documentation that exists but isn't practically accessible in the moment provides limited real protection.
- **Conversations happen with legal representatives but the resident themselves, where capable, isn't directly included.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current advance directive practice for genuine proactive conversation versus paperwork alone.
Week 2	Establish a periodic review schedule for advance directive preferences.
Week 3	Confirm documentation is genuinely, practically accessible during an emergency.
Ongoing	Revisit preferences after any significant change in resident condition.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Advance directive conversation review	Reviews documentation of genuine, proactive advance directive conversations at admission.
DOCUMENT	Periodic review record check	Reviews evidence that advance directive preferences are genuinely revisited over time.
OBSERVE	Accessibility check	Checks whether documented preferences would actually be accessible to staff during a real emergency.

SUPERVISOR TIPS

- **Ask staff how quickly they could locate a specific resident's advance directive during a real emergency.** — A specific, confident answer reveals genuine practical accessibility, not just documentation existing somewhere.
- **Ask a resident or family member whether the conversation felt genuine, not just a form to sign.** — This tests lived experience of the conversation, not documentation compliance alone.

EVIDENCE BASE

[26] The United Nations Principles for Older Persons establish the right of older persons to make decisions about their own care, a principle reflected in established long-term care practice as the resident's right to formulate advance directives, with the facility required to provide written information about these rights and to address resident complaints about facility non-compliance.

[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.

6.2 Palliative Care Is Available Regardless of Terminal Diagnosis

NON-NEGOTIABLE

Palliative care — addressing physical, emotional, social, and spiritual suffering — is genuinely available to any resident who could benefit, not restricted to residents with a terminal diagnosis or treated as identical to, and conditional upon, hospice enrollment.

In plain terms: Palliative care — relief of physical, emotional, social, and spiritual suffering — is available to any resident who would benefit, not only those with a terminal cancer diagnosis and a prognosis.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

A resident with advanced dementia, heart failure, COPD, or frailty is dying — slowly, over months or years — and suffering along the way: breathlessness, pain, anxiety, isolation, loss of meaning. Palliative care addresses this. Yet it is often reserved for cancer, or for the last two weeks, because 'they're not dying yet.' The palliative approach — assess suffering in all its forms, treat what can be treated, support the person and family, plan for what is coming — applies from the moment a resident has a life-limiting condition. Every care home resident has one.

WHAT GOOD LOOKS LIKE

- Palliative care is genuinely available regardless of terminal diagnosis.
- Staff accurately understand and can explain the real distinction from hospice.
- Palliative care genuinely addresses the full range of suffering, not physical symptoms alone.

COMMON FAILURE MODES

- Palliative care is treated as available only for residents with a terminal diagnosis.
- Staff conflate palliative care with hospice, treating them as the same thing.
- Palliative care is narrowed to physical pain management alone.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home where palliative care meant referral to hospice in the last week of life.

BEFORE	Residents with advanced dementia, heart failure, and frailty received active care until they were obviously dying, then hospice was called. Breathlessness in COPD residents was untreated for months. Spiritual needs were not assessed. Families were unprepared for death because no one had said the word.
ACTION	A palliative approach was adopted for all residents with life-limiting conditions: a palliative needs assessment (physical symptoms, emotional, social, spiritual) at admission and quarterly; symptom management protocols for breathlessness, pain, anxiety, and agitation; access to a chaplain or spiritual care; regular family meetings about the trajectory; a link with the community palliative care team for complex needs. Staff completed a palliative care course. 'Would I be surprised if this resident died in the next year?' is asked at every quarterly review.
AFTER	The Monitor reviewed 30 palliative needs assessments with symptom management plans, chaplaincy records, family meeting notes, and staff training records. Interviewed a family who described being prepared for their mother's death. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For every resident, ask: 'Would I be surprised if they died this year?' If no, they need a palliative approach.
2. Assess suffering in all four domains for those residents.
3. Write symptom protocols for breathlessness, pain, and anxiety.
4. Arrange chaplaincy or spiritual care access.

The most common mistake: Reserving palliative care for the last week — the suffering started months earlier.

SELF-ASSESSMENT QUESTIONS

1. Is palliative care genuinely available to any resident who could benefit, not restricted to those with a terminal diagnosis? — *Real availability independent of terminal prognosis, not conflated with hospice eligibility.*

Evidence: Palliative care availability documentation

2. Do staff genuinely understand the distinction between palliative care and hospice, not treat them as interchangeable? — *Genuine, accurate understanding of the real distinction, not confusion between the two.*

Evidence: N/A — tested directly

3. Does palliative care genuinely address physical, emotional, social, and spiritual suffering, not medical pain management alone? — *The full, genuine scope of palliative care, not a narrowed version limited to physical symptoms.*

Evidence: Palliative care scope documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Physical symptom management is genuinely available broadly but emotional and spiritual support is less consistently offered.** — Genuine palliative care addresses the full range of suffering, not physical symptoms in isolation.
- **Some staff understand the real distinction from hospice but others use the terms interchangeably.** — Consistent, accurate understanding across the full care team matters for residents to receive appropriate access.
- **Palliative care is offered when a resident or family specifically asks but not proactively identified as an option.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current palliative care access for genuine independence from terminal diagnosis status.
Week 2	Train staff specifically on the real distinction between palliative care and hospice.
Week 3	Expand palliative care scope to genuinely address emotional, social, and spiritual suffering.
Ongoing	Proactively identify and offer palliative care to residents who could genuinely benefit.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Availability review	Reviews whether palliative care is genuinely available independent of terminal diagnosis status.
ASK	Staff distinction interview	Asks staff to explain the actual difference between palliative care and hospice.
DOCUMENT	Scope review	Reviews palliative care documentation for genuine coverage beyond physical symptom management alone.

SUPERVISOR TIPS

- **Ask a staff member to explain the actual difference between palliative care and hospice.** — A clear, accurate answer reveals genuine understanding, not assumed familiarity.
- **Ask about palliative care for a resident without a terminal diagnosis specifically.** — This tests whether availability is genuinely independent of terminal status, not conflated with hospice eligibility.

EVIDENCE BASE

[27] Established international clinical definitions of palliative care describe it as patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering, addressing physical, intellectual, emotional, social, and spiritual needs, distinct from and not conditional upon a terminal diagnosis or hospice election.

[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.

6.3 Hospice Coordination Follows a Real, Written Agreement, Not Informal Handoff

NON-NEGOTIABLE

When a resident elects hospice care, the facility and the hospice agency operate under a specific, written agreement clearly defining who is responsible for each service — not

an informal handoff where responsibility gaps go unnoticed until something is missed.

In plain terms: When a resident is receiving hospice care, the home and the hospice work under a written agreement that says exactly who does what — not an informal understanding that leaves gaps.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A hospice nurse visits twice a week and prescribes morphine. Who administers it between visits? Who is called at 2am when the resident is in pain? Who tells the family? Who manages the other medications? When the hospice and the home each assume the other is doing it, the resident suffers in the gap. A written agreement defines: the hospice's responsibilities (assessment, symptom management plan, prescriptions, on-call), the home's (daily care, medication administration, monitoring, communication), how they communicate (shared plan, contact numbers, escalation), and how disagreements are resolved. It is signed by both and reviewed annually.

WHAT GOOD LOOKS LIKE

- A specific, written agreement clearly defines responsibility for each service.
- Staff can confidently identify who is responsible for specific aspects of care.
- A real process exists for identifying and closing coordination gaps.

COMMON FAILURE MODES

- Coordination relies on informal or assumed division of responsibility.
- Staff are uncertain who is responsible for specific hospice resident care needs.
- No process exists for identifying gaps before they result in a missed need.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home working with two hospice agencies under informal arrangements.

BEFORE	Hospice involvement was arranged by phone. No written agreement. A resident on hospice care spent a night in severe pain because the home's nurses did not know they could give the PRN morphine the hospice had prescribed, and the hospice on-call number was not in the record. The family complained to both organisations; each blamed the other.
ACTION	A written agreement was negotiated with each hospice: hospice responsibilities (initial and ongoing assessment, symptom management plan, prescriptions, 24-hour on-call, staff education, bereavement support); home responsibilities (daily care, medication administration per hospice plan, monitoring and reporting, family communication); shared documentation in the resident's record; contact numbers on the front page; a monthly review meeting. Home nurses were trained in the hospice symptom protocols.
AFTER	The Monitor reviewed both signed agreements, three resident records with shared hospice plans and on-call numbers, and the monthly meeting minutes. Interviewed a home nurse who described the escalation route. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask your nurses: if a hospice resident is in pain at 2am, what do you do and who do you call?
2. Write an agreement with each hospice defining every responsibility.
3. Put the hospice on-call number on the front of every hospice resident's record.
4. Train home nurses in the hospice symptom protocols.

The most common mistake: Assuming the hospice 'takes over' — the home still provides 90% of the care and must know its role.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific, written agreement with the hospice agency defining responsibility for each service? — *A real, specific written agreement, not an informal or assumed division of responsibility.*

Evidence: Hospice coordination agreement

2. Can staff clearly identify who is responsible for a specific aspect of a hospice resident's care? — *Specific, confident knowledge of the actual division of responsibility, not uncertainty or assumption.*

Evidence: N/A — tested directly

3. Is there a real, documented process for identifying and closing a coordination gap if one is discovered? — *An active process for catching gaps, not an assumption the written agreement alone prevents them.*

Evidence: Coordination gap identification process

COMMON REASONS FOR A PARTIAL ANSWER

- **The written agreement is comprehensive but staff aren't fully familiar with its specific terms.** — An agreement that exists but isn't genuinely known by staff provides limited real coordination benefit.
- **Responsibility is clear for medical care but less clear for personal care and daily support.** — Every category of care needs the same clear definition to prevent a genuine gap.
- **A gap identification process exists but hasn't been genuinely tested with a real coordination issue.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current hospice coordination agreements for specific, comprehensive responsibility definitions.
Week 2	Brief staff thoroughly on the specific terms of the agreement.
Week 3	Establish a real process for identifying and closing coordination gaps.
Ongoing	Review hospice coordination for any real gaps that emerge in practice.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Written agreement review	Reviews the actual written agreement with the hospice agency for specific responsibility definitions.
ASK	Staff responsibility interview	Asks staff to identify who is responsible for a specific element of a current hospice resident's care.
DOCUMENT	Gap identification process review	Reviews the process for identifying and closing coordination gaps between facility and hospice.

SUPERVISOR TIPS

- **Ask to see the actual written agreement for a current or recent hospice resident.** — A specific, real document is the evidence of genuine coordination, not an assumed arrangement.
- **Ask a staff member a specific question about who handles a particular need for a hospice resident.** — A confident, specific answer reveals genuine clarity, not uncertainty papered over.

EVIDENCE BASE

[28] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require a written agreement between the facility and any hospice or palliative care service specifying which entity is responsible for each element of the resident's care.

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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.

6.4 Pain and Suffering Are Actively Anticipated and Treated, Not Just Responded To

NON-NEGOTIABLE

A resident's pain and suffering — physical, emotional, social, spiritual — are actively anticipated and proactively addressed as part of ongoing care, not left until the resident

reports significant distress, particularly for residents whose cognitive or communication impairment makes reporting pain genuinely difficult.

In plain terms: Pain and suffering — physical, emotional, social, spiritual — are anticipated and treated ahead of time as part of the care plan, not only responded to when the resident cries out.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A resident with osteoarthritis will be in pain every morning when she is moved. A resident with advanced heart failure will be breathless at night. A resident whose daughter has stopped visiting will grieve. A resident who was devout and can no longer attend services will suffer spiritually. Each of these is predictable and each can be anticipated: analgesia before morning care, positioning and a fan for breathlessness, a call to the daughter, a chaplain's visit. Responding only to expressed distress means residents suffer until they can make it known — and those with dementia or aphasia may never make it known.

WHAT GOOD LOOKS LIKE

- Pain and suffering are proactively, genuinely assessed on a regular basis.
- A specific, adapted assessment approach exists for residents with communication impairment.
- Assessment genuinely covers the full range of suffering, not physical symptoms alone.

COMMON FAILURE MODES

- Assessment happens only when a resident reports distress themselves.
- The same self-report method is used regardless of a resident's actual communication ability.
- Assessment is narrowed to physical pain, ignoring emotional, social, or spiritual suffering.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home where pain was treated 'as needed.'

BEFORE	Analgesia was PRN, given when a resident reported pain. Residents with dementia rarely reported it and received almost none. Morning care for residents with arthritis was accompanied by cries and resistance, interpreted as 'behaviour.' Emotional and spiritual suffering was not assessed. No anticipatory approach existed.
ACTION	Every resident's care plan now includes an anticipatory suffering assessment: known sources of physical pain and their triggers, emotional needs, social connections, spiritual needs. Interventions are scheduled, not PRN: regular analgesia timed before care for those with chronic pain; a pain scale for dementia (PAINAD) with each set of observations; a fortnightly emotional wellbeing check; spiritual care by preference. Morning care is preceded by analgesia for those who need it.
AFTER	The Monitor reviewed 25 care plans with anticipatory interventions, PAINAD records, and observed morning care for a resident with arthritis who received analgesia 30 minutes before and was calm. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For each resident, list what predictably causes them pain or distress.
2. Schedule the intervention before the trigger — analgesia before morning care.
3. Use a dementia pain scale with every observation set.
4. Add emotional and spiritual needs to the care plan.

The most common mistake: Giving pain relief when the resident cries out — for many residents, crying out is the only way they can tell you it is too late.

SELF-ASSESSMENT QUESTIONS

1. Is pain and suffering actively, proactively assessed, not only addressed when a resident reports distress? — *Genuine, proactive assessment, not reliance on the resident to initiate a report.*

Evidence: Proactive pain assessment documentation

2. Is there a specific approach for assessing pain in residents whose cognitive or communication impairment makes self-reporting difficult? — *A specific, adapted assessment approach, not the same self-report method applied regardless of communication ability.*

Evidence: Non-verbal pain assessment tool

3. Does assessment genuinely cover emotional, social, and spiritual suffering, not physical pain alone? — *The full, genuine scope of suffering, not narrowed to physical symptoms.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Proactive assessment happens for residents who can self-report but relies on observation alone for those who cannot, without a structured tool.** — A structured, validated approach for non-verbal residents provides more reliable identification than observation alone.
- **Physical pain is proactively assessed but emotional and spiritual suffering are addressed only reactively.** — The full scope of suffering deserves the same proactive attention as physical pain specifically.
- **A non-verbal assessment tool exists but isn't consistently used by all staff.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current pain and suffering assessment practice for genuine proactive versus reactive approach.
Week 2	Establish or strengthen a structured, validated assessment tool for non-verbal residents.
Week 3	Expand assessment scope to genuinely cover emotional, social, and spiritual suffering.
Ongoing	Audit assessment consistency across all staff and shifts.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Proactive assessment review	Reviews documentation for genuine, scheduled proactive pain and suffering assessment.
DOCUMENT	Non-verbal assessment tool review	Reviews the specific tool or approach used for residents with communication impairment.
OBSERVE	Scope observation	Observes whether assessment genuinely covers emotional, social, and spiritual dimensions, not physical pain alone.

SUPERVISOR TIPS

- **Ask what specific tool is used to assess pain in a resident who cannot verbally communicate.** — A specific, named tool reveals genuine, structured practice, not reliance on informal observation.
- **Ask how emotional or spiritual suffering is proactively identified, not just physical pain.** — This tests whether the full scope of suffering is genuinely addressed.

EVIDENCE BASE

[29] Established international clinical definitions of palliative care describe anticipating, preventing, and treating suffering as central to genuine palliative practice, distinct from reactive response to reported distress alone.

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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.

6.5 Family Is Genuinely Included in End-of-Life Decisions, Not Just Informed

CORE

Family members are genuinely included as participants in end-of-life care decisions and planning conversations — not merely informed of decisions after they've already been made by clinical staff.

In plain terms: Family members take part in end-of-life decisions and planning — they are asked, listened to, and included — not just told what has been decided.

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

WHY THIS MATTERS

A family that was informed their mother is dying, but not asked what she would have wanted or how they want to be involved, carries grief compounded by exclusion. Genuine inclusion means: family meetings at each stage of decline, with time and a trained facilitator; the family's knowledge of the resident's wishes sought and honoured; their preferences about being present, about the place of death, about rituals, elicited and accommodated; disagreements acknowledged and worked through. The home is a home; the family is part of it.

WHAT GOOD LOOKS LIKE

- Family members are genuine, active participants in end-of-life decisions.
- Families have real opportunity to ask questions and raise concerns before decisions are finalized.
- Families report feeling genuinely included, not just informed.

COMMON FAILURE MODES

- Family members are informed of decisions after clinical staff have already finalized them.
- No real opportunity exists for family questions or concerns before finalization.
- Families report feeling excluded or only nominally consulted.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home where families were called when a resident was 'actively dying.'

BEFORE

Families were informed of decisions — hospital transfer, comfort care — after they were made. The end-of-life call came in the final hours. Families reported feeling excluded and unprepared. One daughter learned her father had

	been placed on comfort care from a care assistant.
ACTION	Family meetings were built into the care pathway: at admission (advance care planning), at any significant deterioration, at the transition to end-of-life care, and after death. A trained nurse facilitates; the physician attends key meetings; the family's understanding, wishes, and preferences are documented; a named family contact receives regular updates; the family is invited to be present and participate in care at the end. A bereavement follow-up call is made at four weeks.
AFTER	The Monitor reviewed 15 end-of-life records with documented family meetings at each stage and family preferences honoured. Interviewed two bereaved families who described being fully included. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three recently bereaved families how they were involved in end-of-life decisions.
2. Build family meetings into the pathway at admission, deterioration, and end of life.
3. Train a nurse to facilitate.
4. Document the family's wishes and preferences.

The most common mistake: Informing families of decisions rather than making decisions with them.

SELF-ASSESSMENT QUESTIONS

1. Are family members genuinely included as participants in end-of-life decisions, not just informed afterward? — *Real, participatory inclusion, not notification of decisions already finalized.*

Evidence: Family participation documentation

2. Are family members given genuine opportunity to ask questions and express concerns before decisions are finalized? — *A real opportunity before finalization, not a decision presented as already*

settled.

Evidence: N/A — tested directly

3. Do families report feeling genuinely included, not just informed, in end-of-life decision-making? — *Real, reported experience of inclusion, not assumed from the process alone.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Inclusion is genuine for major decisions but day-to-day comfort care adjustments aren't discussed with family.** — Ongoing comfort care decisions matter to families too, not only major turning points.
- **Family is included when readily available but less consistently when family members live at a distance.** — Genuine inclusion shouldn't depend on a family member's physical proximity or availability.
- **Conversations happen but families report feeling rushed rather than genuinely heard.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current end-of-life decision-making practice for genuine family participation versus notification.
Week 2	Establish a process ensuring family opportunity to ask questions before decisions are finalized.
Week 3	Build accommodations for family members at a distance to genuinely participate.
Ongoing	Gather family feedback on their genuine experience of inclusion in decision-making.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Family participation review	Reviews documentation for genuine family participation in end-of-life planning, not just notification.
OBSERVE	Decision-making process observation	Observes an actual or simulated end-of-life planning conversation for genuine family inclusion.

Method	What	Detail
ASK	Family experience interview	Asks a family member whether they felt genuinely included in decision-making, not just informed.

SUPERVISOR TIPS

- **Ask a family member directly whether they felt genuinely included, not just informed.** — This tests lived experience, not process compliance alone.
- **Ask how a family member living at a distance would genuinely participate in a decision conversation.** — This reveals whether inclusion is genuinely accessible, not dependent on physical presence.

EVIDENCE BASE

[30] Genuine family participation in end-of-life care decision-making, distinct from notification of decisions already made, is established practice in palliative and end-of-life care literature for both improving decision quality and supporting family wellbeing through the experience.

[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 5 — Cognitive & Behavioral Care**

Standard 7 — Governance & Staffing →

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Standard 7 — Governance & Staffing

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

CRITERIA IN THIS STANDARD

- 7.1 — Staffing Levels Reflect Actual Resident Acuity, Not Just Headcount
- 7.2 — Staffing Data Is Publicly Posted Daily and Genuinely Accurate
- 7.3 — A Data-Driven Quality Improvement Program Genuinely Drives Improvement, Not Just Documentation
- 7.4 — Governance Sustains the Quality Improvement Program Through Leadership Transitions
- 7.5 — Staff Background Screening Prevents Hiring Anyone With a Documented Abuse Finding

7.1 Staffing Levels Reflect Actual Resident Acuity, Not Just Headcount

NON-NEGOTIABLE

Nursing staffing levels are genuinely determined by the actual number, acuity, and diagnoses of current residents, based on a real facility assessment — not a fixed headcount applied regardless of how much the resident population's actual care needs have changed.

In plain terms: The number and skill of nursing staff on each shift are calculated from how many residents there are and how much care they actually need — not a fixed roster set years ago.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is the care home equivalent of hospital 4.4. Understaffed care homes have more pressure injuries, more falls, more infections, more hospital admissions, and more deaths — the evidence is overwhelming. Staffing calculated from resident acuity (a validated dependency tool applied to every resident, summed to hours of care needed per shift) matches staff to need. A roster inherited from a time when the home had 40 independent residents does not match a home that now has 60 with advanced dementia. The calculation must be documented, reviewed when residents change, and used to set the roster.

WHAT GOOD LOOKS LIKE

- Staffing levels genuinely reflect actual resident acuity and diagnoses.
- The facility assessment is current and genuinely informs staffing.
- Staffing responsively adjusts as resident acuity changes.

COMMON FAILURE MODES

- A fixed headcount is maintained regardless of actual resident acuity.
- The facility assessment is outdated or disconnected from actual staffing decisions.
- Staffing remains static even as resident care needs genuinely increase.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home whose roster had not changed in five years while resident acuity rose sharply.

BEFORE

Three care assistants and one nurse per shift, set when the home was largely residential. Half the residents now had advanced dementia; a third needed two-person transfers. Staff were

	exhausted; pressure injuries had doubled; the last inspection cited staffing. No dependency assessment existed.
ACTION	A validated dependency tool was applied to every resident and summed to required care hours per shift. The gap between required and rostered was 35% on day shifts. The owner approved two additional care assistants on days and one on nights. The dependency assessment is repeated monthly and the roster adjusted quarterly. Staffing versus need is reported to the board.
AFTER	The Monitor reviewed the dependency calculation, the revised roster, three quarterly reviews, and the pressure injury and falls trends (both down significantly). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask: when was the roster last calculated from resident need, and with what tool?
2. Apply a validated dependency tool to every resident.
3. Sum the hours needed per shift and compare to the roster.
4. Take the gap to the owner or board with the evidence.

The most common mistake: Keeping the same roster because 'we've always had three on' — the residents have changed even if the number has not.

SELF-ASSESSMENT QUESTIONS

1. Are staffing levels genuinely determined by actual resident acuity and diagnoses, not a fixed headcount alone? — *Real, acuity-based staffing determination, not a static number applied regardless of resident needs.*

Evidence: Facility assessment and staffing determination documentation

2. Is the facility assessment genuinely current, reflecting the actual present resident population? — *A real, current assessment, not one that's grown stale relative to the facility's actual residents.*

Evidence: Current facility assessment

3. When resident acuity increases, does staffing genuinely adjust, not remain fixed regardless of changing need? — *Real, responsive adjustment, not a static staffing level maintained regardless of actual need.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The facility assessment exists and is periodically updated but staffing decisions don't consistently reflect its findings.** — An assessment that doesn't genuinely inform staffing provides limited real protective value.
- **Staffing adjusts for major acuity changes but not for the cumulative effect of smaller changes across the resident population.** — Gradual, cumulative acuity changes deserve the same genuine responsiveness as a single major change.
- **Staffing is adequate for day shifts but less clearly matched to acuity for evening and overnight coverage.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current facility assessment for genuine currency and connection to staffing.
Week 2	Establish a systematic process connecting acuity changes to staffing adjustment.
Week 3	Review staffing adequacy specifically across evening and overnight shifts.
Ongoing	Update the facility assessment and staffing determination as the resident population genuinely changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Facility assessment review	Reviews the facility assessment for genuine currency and connection to actual staffing determination.
DOCUMENT	Staffing-acuity correlation review	Reviews whether staffing levels genuinely correlate with documented resident acuity, not a fixed number.

Method	What	Detail
ASK	Staffing adjustment interview	Asks administration how staffing genuinely adjusts when resident acuity increases.

SUPERVISOR TIPS

- **Ask administration for a specific example of staffing adjusting in response to a genuine acuity increase.** — A real, specific example reveals whether the connection between acuity and staffing is genuine, not just described in policy.
- **Check staffing levels specifically during evening and overnight shifts.** — This is where staffing-to-acuity matching is most likely to show real gaps.

EVIDENCE BASE

[31] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require sufficient nursing staff determined by resident assessments, individual care plans, and the number, acuity, and diagnoses of the facility's actual resident population.

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.

7.2 Staffing Data Is Publicly Posted Daily and Genuinely Accurate

NON-NEGOTIABLE

Daily nurse staffing information is posted publicly in the facility, genuinely reflecting actual hours worked by each category of staff, retained for the required period — not posted data that doesn't match what actually happened, or missing entirely.

In plain terms: The actual nursing hours worked each day, by staff type, are posted where residents and families can see them — and the numbers are true.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Families cannot judge whether a home is adequately staffed unless they can see the numbers. Daily posting — how many nurses, how many care assistants, how many hours, for how many residents — is required by regulation in many jurisdictions and is good practice everywhere. It creates accountability: a home that posts three care assistants and has two on the floor is lying visibly. It must be accurate: actual hours worked, not rostered; updated daily; and reconciled against payroll. A posted number that does not match reality is worse than no posting.

WHAT GOOD LOOKS LIKE

- Daily staffing information is genuinely, visibly posted publicly.
- Posted data accurately reflects actual hours worked, verified against real records.
- Staffing data is genuinely retained for at least 18 months.

COMMON FAILURE MODES

- Staffing information isn't posted, or is posted somewhere not genuinely visible to the public.
- Posted data doesn't match actual hours worked.
- Retention has gaps or doesn't reach the required 18 months.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home that did not post staffing.

BEFORE

No staffing information was available to families. When asked, managers gave the rostered numbers, which did not reflect sick leave, unfilled shifts, or agency gaps. A family who counted staff on a Sunday found two care assistants for 35 residents — the manager had said four.

ACTION

A daily staffing board was installed in the lobby: date, census, and for each shift the actual number of nurses and care assistants on duty and their hours, updated by the shift lead at the

start of each shift from the actual sign-in. The board is photographed daily and reconciled monthly with payroll by the administrator. Discrepancies are reported to the board.

AFTER

The Monitor checked the board against the sign-in sheet on two days (matched), and reviewed three monthly reconciliations against payroll. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count staff on the floor right now. Compare to the roster.
2. Install a daily staffing board in the lobby.
3. Update it from actual sign-in at every shift start.
4. Reconcile monthly with payroll.

The most common mistake: Posting the roster instead of the actual staff — the family who counts will find the difference.

SELF-ASSESSMENT QUESTIONS

1. Is daily staffing information genuinely posted publicly, visible to residents, families, and visitors? — *Real, visible public posting, not data technically available but not genuinely accessible.*

Evidence: Daily staffing posting record

2. Does the posted data genuinely reflect actual hours worked, not planned or idealized staffing? — *Accurate, real data matching what actually happened, not a schedule that doesn't reflect reality.*

Evidence: Actual hours worked documentation

3. Is staffing data retained for at least 18 months, genuinely available on request? — *Real, complete retention, not gaps or missing historical data.*

Evidence: Staffing data retention record

COMMON REASONS FOR A PARTIAL ANSWER

- **Posting happens consistently but the location isn't genuinely visible or accessible to visitors.** — A technically posted notice that's hard to find doesn't achieve genuine public transparency.

- **Data is generally accurate but occasional discrepancies exist between posted and actual hours.** — Even occasional inaccuracy undermines the genuine reliability this transparency requirement is meant to provide.
- **Retention is maintained but not easily retrievable when specifically requested.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current staffing posting location for genuine public visibility.
Week 2	Establish a verification process cross-checking posted data against actual timekeeping.
Week 3	Confirm staffing data retention meets the genuine 18-month requirement.
Ongoing	Audit posted data accuracy against actual records periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Public posting check	Physically verifies daily staffing information is genuinely posted and visible in the facility.
DOCUMENT	Accuracy verification review	Cross-checks posted staffing data against actual timekeeping records for accuracy.
DOCUMENT	Retention record review	Reviews staffing data retention for genuine 18-month completeness.

SUPERVISOR TIPS

- **Physically locate the posted staffing information as a visitor would.** — This tests genuine visibility and accessibility, not just technical compliance.
- **Cross-check a specific day's posted data against actual timekeeping records.** — A specific, real comparison reveals genuine accuracy, not assumed correctness.

EVIDENCE BASE

[32] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require regular, genuinely

accurate public reporting of nurse staffing information, including actual hours worked by each category of licensed and unlicensed nursing staff.

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.

A Data-Driven Quality Improvement Program

7.3 Genuinely Drives Improvement, Not Just Documentation

NON-NEGOTIABLE

The facility maintains an ongoing, data-driven quality assurance and performance improvement program that genuinely identifies and acts on real indicators of care and quality of life — including at least one annual improvement project targeting a genuine high-risk or problem-prone area — not a program that exists in documentation without producing genuine improvement.

In plain terms: The home has a real quality improvement programme — it collects data on falls, pressure injuries, infections, weight loss, and more, finds problems, fixes them, and can show the improvement.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Care homes have measurable outcomes: falls per 1,000 resident-days, pressure injury prevalence, infection rates, weight loss, hospital transfers, antipsychotic use, pain, restraint use. A quality programme collects these monthly, compares them to benchmarks and to the home's own history, identifies the ones that are worse than they should be, runs improvement projects, and remeasures. It is data-driven: the decision to focus on falls comes from the falls data, not from a hunch. And it produces evidence: this rate went from X to Y because we did Z. A programme that produces reports but no change is documentation.

WHAT GOOD LOOKS LIKE

- The quality improvement program genuinely uses real, current data to identify indicators.
- The annual improvement project genuinely targets a real high-risk area.
- Real evidence shows measurable improvement, not just documented activity.

COMMON FAILURE MODES

- The quality improvement program exists as documentation disconnected from actual facility data.
- The annual project is symbolic or doesn't address a genuine high-risk area.
- No real evidence connects quality improvement activity to measurable improvement.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home with a quality committee that met quarterly and reviewed incident reports.

BEFORE

The quality committee discussed individual incidents. No rates were calculated; no benchmarks were used; no improvement projects had been run. The home did not know its falls rate, pressure injury prevalence, or antipsychotic use compared to any standard. Meetings produced minutes and no change.

ACTION

A QAPI programme was built: a monthly dashboard of ten indicators with rates, benchmarks, and trends; a quarterly committee review that selects the two worst indicators for improvement projects; each project follows a plan-do-study-act cycle with a measurable aim; results are reported to the board and posted for staff. First projects: falls (rate down 40%) and antipsychotic use (down 55%). A quality lead was appointed.

AFTER

The Monitor reviewed nine monthly dashboards, two completed improvement projects with

before/after data, and board reports. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Calculate your falls rate and pressure injury prevalence for the last three months.
2. Compare each to a national benchmark.
3. Pick the worst one and run one improvement project.
4. Build a monthly dashboard of ten indicators.

The most common mistake: Reviewing incidents one at a time and never calculating a rate — you cannot improve what you have not measured.

SELF-ASSESSMENT QUESTIONS

1. Does the quality improvement program genuinely use real, current data to identify quality and safety indicators? — *Real data informing the program, not documentation disconnected from reality.*
Evidence: quality improvement data documentation

2. Is there at least one annual improvement project genuinely targeting a real high-risk area? — *A specific, genuine project, not a symbolic initiative.*
Evidence: Annual improvement project documentation

3. Is there real evidence the program has driven measurable improvement, not just documented activity? — *Actual, measurable improvement, not activity without demonstrated effect.*
Evidence: Improvement outcome evidence

COMMON REASONS FOR A PARTIAL ANSWER

- **Data collection is thorough but analysis doesn't consistently translate into genuine corrective action.** — Data without genuine action doesn't provide the real improvement this program is meant to drive.
- **The annual project addresses a real area but scope doesn't match the facility's actual size and complexity.** — A project's scope should genuinely reflect the facility's own actual services and resources, not a generic template.
- **Improvement is documented but not clearly measured against a specific, quantifiable baseline.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current quality improvement program for genuine, data-driven practice versus documentation alone.
Week 2	Select or confirm an annual improvement project genuinely targeting a real high-risk area.
Week 3	Establish specific, measurable baselines for tracking genuine improvement.
Ongoing	Review quality improvement outcomes against measurable baselines to confirm genuine improvement.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Data-driven practice review	Reviews whether the quality improvement program genuinely uses real, current facility data.
DOCUMENT	Annual project review	Reviews the annual improvement project for genuine focus on a real high-risk area.
DOCUMENT	Outcome evidence review	Reviews evidence of genuine, measurable improvement resulting from quality improvement activity.

SUPERVISOR TIPS

- **Ask for the specific, real data behind the current annual improvement project.** — Real, specific data reveals whether the program is genuinely data-driven, not just documented as such.
- **Ask for measurable evidence that a past quality improvement project produced genuine improvement.** — A real, measurable outcome distinguishes genuine improvement from activity recorded for compliance alone.

EVIDENCE BASE

[33] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, require an effective, comprehensive, data-driven quality assurance and performance improvement program with documented evidence of systematic identification, investigation, and prevention of adverse events.

7.4

Governance Sustains the Quality Improvement Program Through Leadership Transitions

NON-NEGOTIABLE

The facility's governing body holds genuine, documented accountability for the quality improvement program continuing through leadership and staffing transitions, with adequate resourcing — staff time, technical training — not a program that quietly weakens or lapses whenever key personnel change.

In plain terms: The owners or board are accountable for the quality programme continuing when the manager changes — it is in the governance documents, reviewed by the board, not dependent on one person.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Care home managers change frequently. The quality programme that the last manager built collapses when she leaves and the new manager has other priorities. Governance means the programme belongs to the organisation, not the individual: the board's terms of reference require it; the board receives the dashboard quarterly; the quality lead reports to the board, not only to the manager; the programme is in the new manager's induction; the board asks about it at every meeting. Leadership transitions are the moment quality programmes die; governance is what keeps them alive.

WHAT GOOD LOOKS LIKE

- The governing body holds genuine, documented institutional accountability.

COMMON FAILURE MODES

- Accountability rests informally on one individual, not the governing body itself.

- The quality improvement program has genuinely continued through real leadership transitions.
- The program is adequately resourced with real staff time and training.

- The program has weakened or lapsed during a past leadership transition.
- The program lacks genuine, adequate resourcing to function.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home that had lost its quality programme twice in five years to management changes.

BEFORE

The quality programme was the manager's project. When she left, the new manager did not continue it; the dashboard stopped; the improvement projects stalled. The board had never seen the dashboard and did not know the programme had ended. The next manager started again from scratch.

ACTION

The board amended its terms of reference to require a quality programme with defined indicators, quarterly board review, and a named quality lead reporting to the board. The programme was documented in a manual independent of any individual. The manager's job description includes maintaining it; the induction for any new manager includes a board briefing on it. The board's agenda has a standing quality item.

AFTER

The Monitor reviewed the amended terms of reference, the programme manual, four quarterly board minutes with quality review, and — following a subsequent manager change — evidence that the programme continued without interruption. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask: if the manager left tomorrow, would the quality programme survive?

2. Put the programme in the board's terms of reference.
3. Have the quality lead report to the board quarterly.
4. Document the programme in a manual, not in the manager's head.

The most common mistake: A quality programme that belongs to the manager — it leaves when she does.

SELF-ASSESSMENT QUESTIONS

1. Does the governing body hold genuine, documented accountability for the quality improvement program? — *Real, institutional accountability, not dependence on one person's commitment.*
Evidence: Governing body accountability documentation
2. Has the program genuinely continued through a real leadership or staffing transition, without lapsing? — *Real, demonstrated continuity, not an assumption it would hold up.*
Evidence: quality improvement continuity record through transitions
3. Is the program adequately resourced, not left to function without real support? — *Genuine, adequate resourcing, not a program expected to run on goodwill alone.*
Evidence: quality improvement resourcing documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Governing body accountability is documented but genuine engagement in practice is inconsistent.** — Documented accountability without genuine, active engagement provides limited real protection against program fragility.
- **The program has weathered smaller staffing changes but hasn't yet been tested by a major leadership transition.** — Genuine resilience is best confirmed by how the program holds up under a real, significant transition, not assumed from smaller changes alone.
- **Resourcing is generally adequate but technical training for quality improvement-specific skills is limited.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current quality improvement accountability structure for genuine governing body ownership.

When	What
Week 2	Establish documented processes ensuring program continuity through future transitions.
Week 3	Assess and strengthen resourcing, including quality improvement-specific technical training.
Ongoing	Review program continuity and resourcing whenever a genuine leadership transition occurs.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Governance accountability review	Reviews documentation for genuine governing body accountability, not informal individual dependence.
DOCUMENT	Transition continuity review	Reviews evidence that the quality improvement program genuinely continued through a real past leadership transition.
DOCUMENT	Resourcing review	Reviews whether the program receives genuine, adequate resourcing.

SUPERVISOR TIPS

- **Ask the governing body directly about their own role in quality improvement accountability, not just administration.** — A specific, confident answer from governance itself reveals genuine institutional ownership.
- **Ask about a real, past leadership transition and how the quality improvement program held up.** — A real example reveals genuine resilience, not just an assumption the structure would hold.

EVIDENCE BASE

[34] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, establish that the governing body or executive leadership is responsible and accountable for ensuring a quality improvement program is sustained during transitions in leadership and staffing, and is adequately resourced.

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.

7.5 Staff Background Screening Prevents Hiring Anyone With a Documented Abuse Finding

NON-NEGOTIABLE

Every staff member is screened against relevant background checks and any national or regional care-worker registry before hire, with anyone found guilty of abuse, neglect, exploitation, or resident mistreatment genuinely excluded from employment — not a screening process that exists on paper but doesn't reliably catch a real, documented finding.

In plain terms: Every staff member is checked against criminal records and the care-worker abuse registry before they start — and anyone with an abuse finding is not hired, no exceptions.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Care home residents are among the most vulnerable people in society, and people who abuse them move from home to home. A registry of care workers with substantiated abuse findings exists in most jurisdictions precisely to stop this. Checking it — along with criminal records — before hire is the minimum. The check must be done before the person works a single shift, must cover every category of staff including kitchen, cleaning, and agency, and must be documented. A home that hires first and checks later has put an unknown person among its residents.

WHAT GOOD LOOKS LIKE

- Every staff member receives genuine, complete pre-hire background screening.
- Anyone with a documented abuse or

COMMON FAILURE MODES

- Background screening is inconsistent or incomplete for some hires.
- The screening process has gaps that could miss a documented finding.

mistreatment finding is reliably excluded.

- Screening is genuinely repeated periodically, not only at initial hire.

- Screening happens only once, never rechecked after initial hire.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home with an HR process that checked references but not registries.

BEFORE

New staff provided two references and started. Criminal record checks were requested but staff often started before results arrived. The care-worker registry was not checked. A care assistant was found to have a substantiated abuse finding from a previous employer, discovered only when a resident's family recognised her name.

ACTION

A pre-employment screening policy was written: criminal record check, care-worker registry check, professional registration check (for nurses), and two verified references — all completed and documented before the first shift, no exceptions, including agency and volunteer staff. HR maintains a screening file per person. A monthly audit checks that no one has started without complete screening. The policy was adopted by the board.

AFTER

The Monitor reviewed 20 staff files: all with complete screening dated before the start date. Reviewed the monthly audit (100% compliance for six months). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten recent staff files. Was the registry checked before their first shift?
2. Write the policy: no start without complete screening.
3. Include agency, volunteer, kitchen, and cleaning staff.

4. Audit monthly.

The most common mistake: Letting staff start 'pending' checks — the check exists to happen before, not after.

SELF-ASSESSMENT QUESTIONS

1. Is every staff member genuinely screened against relevant background checks and any national or regional care-worker registry before hire? — *Real, complete screening for every hire, not an inconsistent or partial process.*

Evidence: Pre-hire background screening record

2. Is anyone with a documented abuse, neglect, or mistreatment finding genuinely excluded from employment? — *A firm, reliable exclusion, not a screening process that misses real findings.*

Evidence: N/A — tested directly

3. Is screening genuinely repeated or rechecked periodically, not only performed once at initial hire? — *Ongoing, periodic verification, not a one-time check that could miss a finding entered later.*

Evidence: Periodic rescreening record

COMMON REASONS FOR A PARTIAL ANSWER

- **Screening is thorough for direct care staff but less consistent for support or contracted staff.** — Anyone with resident access deserves the same genuine screening, regardless of their specific role.
- **State registry checks are performed but not consistently documented as verified.** — Undocumented verification is difficult to distinguish from a check that wasn't genuinely completed.
- **Initial screening is thorough but periodic rechecking isn't consistently performed.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current background screening practice for completeness across all staff roles, including contracted staff.
Week 2	Establish consistent, documented registry verification for every hire.

When	What
Week 3	Establish a periodic rescreening schedule beyond initial hire.
Ongoing	Audit screening completeness and documentation for new hires.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Pre-hire screening review	Reviews background screening records for a sample of recent hires for genuine completeness.
DOCUMENT	Registry check verification	Verifies actual registry checks were genuinely performed, not assumed.
DOCUMENT	Periodic rescreening review	Reviews whether screening is genuinely repeated periodically after initial hire.

SUPERVISOR TIPS

- **Ask to see the actual background screening documentation for a specific, recent hire.** — A specific, real record is the genuine evidence of a functioning process, not an assumed one.
- **Ask specifically about screening practice for contracted or agency staff, not only direct employees.** — This is where screening consistency most commonly shows real gaps.

EVIDENCE BASE

[35] Established long-term care regulatory principles, recognized in various forms across many countries' care standards, prohibit employing individuals with a documented, substantiated finding of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property, verified through the relevant national or regional screening mechanism.

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.

**Self-assess against these
criteria →**

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

**Standard 8 — Medical
Tourism →**

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Standard 8 — Medical Tourism

10 criteria · 7 non-negotiable · 3 core · Version 3.0

CRITERIA IN THIS STANDARD

- 8.1 — Pricing Transparency for Ongoing International Placement
- 8.2 — Periodic Condition Updates Reach Family and Home-Country Physician
- 8.3 — Language Access for the Resident and Visiting Family
- 8.4 — Family Visit Travel and Accommodation Coordination
- 8.5 — Long-Term Residency and Legal Status Documentation Support
- 8.6 — International Complaint and Redress Process
- 8.7 — Placement Facilitator and Agent Verification
- 8.8 — Repatriation and End-of-Life Planning Across Borders Is Discussed in Advance
- 8.9 — Cultural and Dietary Continuity for the International Resident
- 8.10 — Time Zone and Distance-Adapted Family Communication

8.1 Pricing Transparency for Ongoing International Placement

NON-NEGOTIABLE

An international family receives a complete, written breakdown of ongoing monthly costs, included and excluded services, and any anticipated future cost changes tied to care level increases — before placement is finalized, not costs that emerge only after the resident has already moved in.

In plain terms: An international family gets a complete written breakdown of monthly costs, what is included, what is not, and what could change — before placing their relative.

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

WHY THIS MATTERS

A family in another country placing a parent in a care home cannot visit the office to ask questions or compare invoices with other families. They depend entirely on what is written. Fee transparency for international placement means: a complete monthly cost with every included service, every extra with its price, the average total for a typical resident, the currency and payment method, how and when fees change, what happens if the resident's needs increase, and what happens if funds run out. In their language. Signed before admission.

WHAT GOOD LOOKS LIKE

- Families receive a complete, written breakdown of ongoing costs before placement.
- Anticipated future cost changes are specifically disclosed in advance.
- A transparent process communicates any actual cost change.

COMMON FAILURE MODES

- Cost disclosure is partial or given only after placement.
- Future cost changes tied to care level increases aren't disclosed in advance.
- Cost increases appear without prior communication.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home accepting residents from three neighbouring countries.

BEFORE	International families received the same fee sheet as domestic families — base rate only, in the local language. Invoices included extras and currency conversion charges they had not anticipated. Two families disputed charges by email for months; one withdrew their parent.
ACTION	An international fee schedule was created in English and the three relevant languages: base monthly fee, every additional service with price, the average total for the resident's assessed needs, the currency, payment method and any conversion cost, the annual review and notice period for fee changes, and the process if needs change. It is sent before admission with a sample invoice and signed. Any charge outside the schedule requires written family agreement.
AFTER	The Monitor reviewed 12 international admission files with signed fee schedules and invoices matching them. Interviewed one family by email who confirmed the invoice matched expectations. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Compare an international family's last three invoices to what they were told before admission.
2. Build a complete fee schedule with every extra priced.
3. Translate it and send it with a sample invoice.
4. Require written agreement for anything outside it.

The most common mistake: Sending the domestic fee sheet in the local language to a family abroad.

SELF-ASSESSMENT QUESTIONS

1. Does the family receive a complete, written breakdown of ongoing monthly costs before placement is finalized? — *Written and complete,*

covering the ongoing commitment, not a one-time figure.

Evidence: Written ongoing cost breakdown

2. Are anticipated future cost changes tied to care level increases specifically disclosed in advance? — *Genuine advance disclosure of likely future changes, not costs that surprise the family later.*

Evidence: Future cost change disclosure

3. Is there a specific, transparent process for communicating any actual cost change once the resident is placed? — *A defined, transparent process, not an unexplained addition to the bill.*

Evidence: Cost change communication protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Base monthly costs are disclosed clearly but potential future care-level increases aren't specifically flagged.** — A family arranging placement from abroad benefits from knowing likely future costs, not only the current rate.
- **Disclosure is written but not specifically confirmed as understood before the family commits.** — Distance and possible language barriers make active confirmation of understanding genuinely important here.
- **Cost change notification exists but isn't adapted for a family in a different time zone.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current international placement cost disclosure for completeness and advance timing.
Week 2	Build a complete, written disclosure template covering ongoing costs and anticipated future changes.
Week 3	Establish a transparent, distance-appropriate cost change notification process.
Ongoing	Audit actual costs against original disclosure for a sample of international placements.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Ongoing cost disclosure review	Reviews written cost breakdowns provided to international families for completeness and clarity on ongoing nature.
DOCUMENT	Future cost disclosure review	Reviews whether anticipated care-level cost changes are specifically disclosed in advance.
ASK	Family cost experience interview	Asks an international family whether ongoing costs have matched what they were told before placement.

SUPERVISOR TIPS

- **Ask an international family directly whether ongoing costs have matched what they were told.** — This is the clearest, most direct test of genuine pricing transparency over time.
- **Ask to see the actual written disclosure given to a specific, real family.** — A real, specific document reveals whether disclosure genuinely happens, not just exists as policy.

EVIDENCE BASE

[36] WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force to an ongoing, long-term financial commitment arranged by a family with limited ability to reassess after placement.

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.

8.2 Periodic Condition Updates Reach Family and Home-Country Physician

NON-NEGOTIABLE

The resident's family and, where relevant, their home-country physician receive genuine, periodic updates on the

resident's condition and care — not only at admission, and not only when a family member happens to ask.

In plain terms: The resident's family abroad — and their home-country doctor where relevant — get regular, meaningful updates on the resident's condition, not just a call when something goes wrong.

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

WHY THIS MATTERS

A family thousands of kilometres away cannot drop in. They depend on the home to tell them how their mother is: whether she is eating, whether she is content, whether her dementia is progressing, whether she has fallen. A monthly update — by email, a scheduled video call, a written summary — keeps them connected and informed. A home-country physician who is still involved needs clinical updates. Silence is not reassurance; families in silence assume the worst. And the call that only comes in a crisis is a call that arrives when it is too late to plan.

WHAT GOOD LOOKS LIKE

- Family receives genuine, proactive, periodic updates.
- Significant changes are promptly communicated, not delayed to a scheduled check-in.
- Home-country physicians are kept genuinely informed where relevant.

COMMON FAILURE MODES

- Family hears from the facility only when they specifically ask.
- Significant changes wait for the next routine update rather than prompt communication.
- Home-country physicians receive no ongoing information.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home where international families were contacted only for emergencies.

BEFORE	Families abroad received a call when the resident was hospitalised or died. No routine updates. Families phoned the home repeatedly for information and were told 'she's fine.' One family learned of their father's significant decline only when they visited after six months.
ACTION	A communication plan is made for every international resident: a named contact at the home; a monthly written update (condition, mood, eating, activities, any changes, photographs with consent) in the family's language; a scheduled video call monthly or as requested; immediate contact for any significant change, with a defined list of what counts; clinical updates to the home-country physician quarterly where the family wishes. The plan is reviewed with the family at admission.
AFTER	The Monitor reviewed 12 international resident files with monthly updates sent, video call logs, and significant-change contacts. Interviewed one family by video who described feeling connected. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three international families when they last received an update that was not an emergency.
2. Assign a named contact per international resident.
3. Send a monthly written update with photographs.
4. Schedule a monthly video call.

The most common mistake: Only calling when something goes wrong — silence teaches families that no news is bad news.

SELF-ASSESSMENT QUESTIONS

1. Does the family receive genuine, periodic updates on the resident's condition, not only when they ask? — *Proactive, scheduled updates, not communication that depends entirely on the family initiating*

contact.

Evidence: Periodic update record

2. Is a significant change in condition specifically communicated promptly, not folded into the next routine update? — *Prompt, specific communication for significant changes, not delayed until a scheduled check-in.*

Evidence: Significant change notification record

3. Where relevant, is the resident's home-country physician also kept genuinely informed? — *Real, ongoing physician communication, not contact limited to the family alone.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Updates happen periodically but the schedule isn't consistently maintained across all international residents.** — Every international family deserves the same reliable, periodic communication.
- **Updates cover clinical status but not day-to-day quality of life or wellbeing.** — A family separated by distance often values wellbeing information as much as clinical status.
- **Communication happens but isn't adapted for the family's time zone or preferred method.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current family communication practice for genuine, proactive periodic updates.
Week 2	Establish a defined update schedule and prompt significant-change notification process.
Week 3	Confirm communication methods are adapted to each family's time zone and preference.
Ongoing	Audit update consistency for international families specifically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Periodic update record review	Reviews records for genuine, proactive periodic updates to family, not reactive communication alone.
DOCUMENT	Significant change notification review	Reviews whether significant condition changes are promptly communicated, not delayed.
ASK	Family communication interview	Asks a family member how often they genuinely hear from the facility, and whether it's proactive.

SUPERVISOR TIPS

- **Ask a family member when they last heard from the facility without having asked first.** — This tests genuine proactive communication, not reactive response to family inquiry.
- **Ask how a significant condition change would actually reach the family, and how quickly.** — A specific, confident answer reveals a genuine process, not an assumption.

EVIDENCE BASE

[37] Continuity of care and family engagement across international distance is identified in cross-border long-term care literature as requiring proactive, periodic communication, distinct from reactive updates provided only when specifically requested.

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.

8.3 Language Access for the Resident and Visiting Family

NON-NEGOTIABLE

A genuinely competent interpreter is available for the resident's ongoing care conversations and for family members during visits — not an ad hoc arrangement using

whichever staff member happens to speak some of the family's language.

In plain terms: A competent interpreter is available for the resident's care conversations and for family visits — not staff who 'speak a bit,' and never another resident.

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

WHY THIS MATTERS

A resident who cannot communicate with staff in her own language cannot say she is in pain, cannot refuse care, cannot make a choice, cannot tell anyone she is afraid. A visiting family who cannot communicate with staff cannot understand their mother's condition or advocate for her. In long-term care, language access is not for the occasional consultation; it is for daily life. It means: a competent interpreter (professional, or a trained bilingual staff member) for care planning, health conversations, and family meetings; key daily phrases learned by staff; visual aids; and a plan for the resident's language needs in their care plan.

WHAT GOOD LOOKS LIKE

- A competent interpreter is genuinely available for ongoing care conversations.
- Interpreter access is specifically arranged in advance for family visits.
- Genuine, substantive communication about care decisions is possible.

COMMON FAILURE MODES

- Interpreter access exists only at admission, not for ongoing care.
- Family visit interpretation is improvised, not planned in advance.
- Communication is limited to superficial exchange, not genuine care discussion.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home with four international residents whose first languages were not spoken by any staff.

BEFORE

Communication with these residents was by gesture. Care planning happened without their

	input. Family visits involved a family member interpreting for their own relative's medical review. One resident's persistent distress was later found to be untreated dental pain she had been unable to describe.
ACTION	A phone interpretation service was contracted, covering all four languages, available 24 hours. Care planning, health reviews, and family meetings use it. Two bilingual staff completed medical interpreter training. Each international resident's care plan has a language section: key phrases, communication aids, preferred interpreter arrangement. Staff learned ten daily phrases in each language. A pictorial communication board is in each resident's room.
AFTER	The Monitor reviewed four care plans with language sections, interpretation service logs, and observed a care review conducted with the phone service. Interviewed a family who confirmed they no longer interpret for medical conversations. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List residents whose first language no staff member speaks.
2. Contract a phone interpretation service.
3. Add a language section to each of their care plans.
4. Stop using family members to interpret for clinical conversations.

The most common mistake: Managing by gesture — a resident who cannot speak to anyone has been silenced.

SELF-ASSESSMENT QUESTIONS

1. Is a genuinely competent interpreter available for the resident's ongoing care conversations, not only at admission? — *Real, ongoing interpreter access, not limited to a single initial conversation.*
Evidence: Interpreter access record

2. Is interpreter access specifically arranged for family visits, not improvised on the day? — *Planned in advance for scheduled visits, matched to the family's actual language.*

Evidence: Family visit interpreter arrangement record

3. Can the resident and family genuinely communicate about care decisions, not just exchange pleasantries? — *Genuine, substantive communication access, not superficial interaction alone.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Interpreter access is reliable for scheduled care conferences but not for informal, spontaneous conversations.** — Meaningful communication can happen outside formally scheduled conversations too.
- **Advance arrangement happens for planned visits but not for unplanned or shorter family visits.** — A shorter or less-planned visit still deserves the same genuine communication access.
- **Interpretation is available but not consistently used for actual care decision discussions.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current interpreter access for genuine ongoing coverage, not admission-only.
Week 2	Establish advance-arranged interpreter access for scheduled family visits.
Week 3	Extend interpreter access to informal as well as formal care conversations.
Ongoing	Confirm interpreter access for every planned family visit.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Ongoing interpreter access review	Reviews records for genuine, ongoing interpreter access beyond admission.
ASK	Family visit arrangement interview	Asks staff how interpreter access is arranged in advance of a scheduled family visit.

Method	What	Detail
OBSERVE	Communication quality observation	Observes an interpreted interaction for genuine, substantive communication, not superficial exchange.

SUPERVISOR TIPS

- **Ask about interpreter access for a family visit specifically, not just admission.** — This is where access most commonly narrows relative to the initial conversation.
- **Observe an actual interpreted care conversation if a visit is occurring.** — Direct observation reveals whether communication is genuinely substantive.

EVIDENCE BASE

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

[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.

8.4 Family Visit Travel and Accommodation Coordination CORE

The facility provides or coordinates genuine support for family members' travel and accommodation logistics when visiting from abroad — not leaving a family to navigate an unfamiliar country alone during what is often a limited, emotionally significant visit.

In plain terms: The home helps families visiting from abroad with the practicalities — accommodation nearby, transport, visiting times that fit their trip — rather than leaving them to find their way.

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

WHY THIS MATTERS

A family flying in for a week to see their father needs somewhere to stay, a way to get to the home, and enough time with him to make the journey worthwhile. A home that provides a list of nearby accommodation, arranges airport pick-up or gives clear directions, offers flexible visiting hours for the duration of the visit, and a space for the family to spend time together, makes the visit possible. A home that says 'visiting hours are 2 to 4' to a family who flew ten hours has failed them and their relative.

WHAT GOOD LOOKS LIKE

- Genuine coordination support is provided for family visit logistics.
- Accommodation genuinely supports maximum time with the resident.
- A specific logistics contact is available during the family's visit.

COMMON FAILURE MODES

- Families receive only a generic list of options with no real coordination.
- Accommodation logistics consume significant time that could be spent with the resident.
- No specific contact exists for family logistics problems during the visit.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home with residents whose families visited from abroad two or three times a year.

BEFORE

Families arranged their own logistics and were subject to standard visiting hours. One family stayed in a hotel an hour away and could visit for two hours a day. Another arrived at the home at 9pm after a long flight and was turned away. There was no family room.

ACTION

An international family visit protocol was written: a vetted accommodation list within 15 minutes, with a negotiated rate at one; airport transfer arranged on request; unrestricted visiting for the duration of an international visit, including meals with the resident; a family room with a kitchenette available; a named contact to plan the visit in

advance. The protocol is sent with the fee schedule.

AFTER

The Monitor reviewed the protocol, the accommodation list, and three recent international visits with logistics arranged. Interviewed a family who described the visit as 'made easy.' Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask the last three international families how they arranged their visit and how it went.
2. Create a vetted accommodation list near the home.
3. Waive visiting hours for international visits.
4. Assign a contact to plan each visit.

The most common mistake: Applying standard visiting hours to a family who flew across the world.

SELF-ASSESSMENT QUESTIONS

1. Does the facility provide or genuinely coordinate travel and accommodation support for visiting family? — *Real coordination, not information the family must act on entirely alone from abroad.*

Evidence: Family visit coordination documentation

2. Is accommodation genuinely convenient to the facility, supporting maximum time with the resident? — *Genuine proximity and convenience, not logistics that eat into limited visit time.*

Evidence: N/A — tested directly

3. Is there a specific point of contact for family logistics problems during their visit? — *A specific, known contact, not an assumption the family will manage independently.*

Evidence: Family logistics contact protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Coordination support is offered for the arrival but not for return travel.** — Logistics support matters for the full visit, not only its beginning.
- **Accommodation recommendations exist but aren't verified for genuine proximity and convenience.** — An unverified

recommendation may not actually support maximum time with the resident.

- **A contact exists but isn't clearly communicated to the family before their visit begins.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current family visit logistics support against genuine coordination versus informational lists.
Week 2	Verify accommodation recommendations for genuine proximity and convenience.
Week 3	Establish a specific, communicated logistics contact for family visits.
Ongoing	Gather family feedback on visit logistics coordination quality.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Coordination support review	Reviews what genuine travel and accommodation coordination is provided to visiting families.
ASK	Accommodation convenience interview	Asks a visiting family whether accommodation genuinely supported time with their relative.
DOCUMENT	Logistics contact review	Reviews the specific point of contact provided for family logistics issues during a visit.

SUPERVISOR TIPS

- **Ask a recent visiting family how logistics support actually worked in practice.** — Real experience reveals more than a description of intended coordination.
- **Ask how much of a typical family visit is spent on logistics versus time with the resident.** — This reveals whether coordination genuinely protects the value of a limited visit.

EVIDENCE BASE

[39] Patient and family-reported experience research in medical tourism consistently identifies logistical coordination, not clinical quality alone, as a major determinant of overall satisfaction, a principle that applies with particular force to time-limited family visits.

[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.

8.5 Long-Term Residency and Legal Status Documentation Support

NON-NEGOTIABLE

The facility provides the specific documentation an international resident needs for their long-term residency or extended-stay legal status, correctly and promptly — not generic paperwork suited only to a short medical visa, applied to what is actually an ongoing, long-term placement.

In plain terms: The home provides the documents an international resident needs for their residency permit, visa extension, or legal stay — correctly, promptly, and in the format the authorities require.

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

WHY THIS MATTERS

An international resident in a care home may need a long-term residency permit, a visa extension, a medical certificate for the immigration authority, or proof of care arrangements for the home country's pension or insurance. Without the right document at the right time, the resident's legal status lapses — and a care home resident with no legal status is in an impossible position. The home should know what documents the relevant authorities require, have templates,

and produce them promptly on request. This is administrative, but it is the home's responsibility because the resident cannot do it themselves.

WHAT GOOD LOOKS LIKE

- Documentation is specifically matched to long-term residency needs.
- Documentation is provided with realistic lead time for extended-stay processing.
- A real, ongoing renewal support process exists for the duration of placement.

COMMON FAILURE MODES

- Documentation is generic, designed for short-term medical visits rather than long-term residency.
- Documentation arrives too late for realistic long-term status processing.
- No process exists to support status renewal as the placement continues.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home with six international residents from two countries.

BEFORE

Documentation requests from families were handled ad hoc. A resident's residency permit lapsed because the home's medical certificate did not meet the immigration authority's format and was rejected; the family was abroad and could not resolve it quickly. Nobody at the home knew what the authorities required.

ACTION

The administrator contacted the immigration authority and the two relevant consulates and obtained the document requirements. Templates were created for the residency medical certificate, the proof of care arrangement, and the pension continuation letter. A calendar tracks each international resident's permit expiry with a 90-day reminder. Requests are fulfilled within five working days.

AFTER

The Monitor reviewed the templates, the requirement documents, the expiry calendar, and

a log of 14 documents issued within timeframe.
Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every international resident and their legal status expiry date.
2. Contact the immigration authority for their exact document requirements.
3. Build templates.
4. Set 90-day reminders.

The most common mistake: Not knowing when an international resident's legal status expires until it has.

SELF-ASSESSMENT QUESTIONS

1. Does the facility provide documentation specific to long-term residency or extended-stay status, not short-term medical visa paperwork? — *Documentation genuinely matched to the actual long-term nature of the placement.*

Evidence: Long-term residency documentation record

2. Is documentation provided with enough lead time for realistic long-term status processing? — *Genuine lead time reflecting the real processing timelines for extended-stay status.*

Evidence: N/A — tested directly

3. Is there a specific process for renewing or maintaining legal status over the course of an ongoing placement? — *A real, ongoing process, not documentation support limited to initial placement alone.*

Evidence: Status renewal support process

COMMON REASONS FOR A PARTIAL ANSWER

- **Initial documentation is appropriate but renewal support isn't consistently offered as the placement continues.** — Long-term status needs are ongoing, not resolved once at the start of placement.
- **Lead time is adequate for common cases but not for countries with longer extended-stay processing times.** — Processing time varies significantly by country, and lead time should reflect the family's actual situation.

- **Documentation is accurate but the family isn't proactively reminded of renewal deadlines.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current documentation practice for genuine match to long-term residency needs.
Week 2	Establish country-specific extended-stay documentation checklists.
Week 3	Build a proactive renewal reminder and support process.
Ongoing	Track legal status renewal timelines for international residents.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Documentation type review	Reviews documentation provided for genuine match to long-term residency needs, not short-term visa templates.
ASK	Lead time interview	Asks staff how far in advance long-term status documentation is typically provided.
DOCUMENT	Renewal support review	Reviews the process for supporting legal status renewal over an ongoing placement.

SUPERVISOR TIPS

- **Ask for a real example of long-term status documentation provided for a specific resident's country.** — A real, specific example reveals genuine, correct matching to actual residency needs.
- **Ask how the facility tracks upcoming legal status renewal deadlines.** — A specific, confident answer reveals a genuine, proactive process.

EVIDENCE BASE

[40] Medical and long-term care travel facilitation literature identifies documentation delays and errors as a leading cause of placement disruption for international residents, with extended-stay legal status requiring genuinely distinct documentation from short-term medical visas.

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

8.6 International Complaint and Redress Process

NON-NEGOTIABLE

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

In plain terms: Families abroad can complain and seek redress from their own country — by email, phone, or web — and there is evidence that such complaints are addressed.

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

WHY THIS MATTERS

This is the long-term care version of the international complaint process. A family who cannot visit cannot complain in person. The process must work by email or phone, in a language the family reads, with a named person, response times, and a redress route — a refund policy for service failures, a mediation option, an external ombudsman. Evidence means complaints from abroad have been received and resolved. A home that reports no international complaints usually has no way to receive them.

WHAT GOOD LOOKS LIKE

- The complaint channel is genuinely reachable and usable from abroad.
- The channel accounts for relevant languages and

COMMON FAILURE MODES

- The complaint process functionally requires physical presence or local language fluency.

- time zone differences.
- Real, documented evidence shows complaints are genuinely addressed.

- No accommodation exists for time zone or language barriers.
- No documented evidence exists that complaints from international families are addressed.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home whose complaints process was a form at reception.

BEFORE

International families had no route. They complained by email to the manager, who sometimes responded. Nothing was logged. A family who complained about their mother's weight loss received no response for six weeks and escalated to the embassy.

ACTION

An international complaints route was created: a dedicated email and phone line, in the families' languages; the administrator as named contact; acknowledgement within 3 working days, investigation and response within 21; a redress policy (fee adjustment for documented service failures, escalation to the regional care ombudsman); complaints logged and reviewed monthly. The route is on the fee schedule and in every monthly update.

AFTER

The Monitor reviewed the complaints log: 6 international complaints in six months, all responded to within timeframe, one with a fee adjustment. Reviewed the redress policy. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Try to complain about your home from abroad. Is there a route?
2. Create a dedicated email and phone line in the families' languages.

3. Name a contact and set response times.
4. Write a redress policy.

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

SELF-ASSESSMENT QUESTIONS

1. Is there a specific complaint channel genuinely reachable from the family's home country? — *Genuine remote accessibility, not a channel that functionally only works locally.*

Evidence: Complaint channel documentation

2. Is the complaint channel accessible in relevant languages and adapted for time zone differences? — *Genuine accessibility accounting for real language and time zone barriers.*

Evidence: N/A — tested directly

3. Is there real, documented evidence that complaints from international families are actually addressed? — *Genuine follow-through, not a channel that produces no real response.*

Evidence: Complaint resolution record

COMMON REASONS FOR A PARTIAL ANSWER

- **A remote complaint channel exists but response times are significantly slower than for local complaints.** — A technically accessible channel that responds too slowly doesn't provide genuine redress.
- **The channel is accessible by email but responses aren't genuinely timed to the family's time zone.** — Technical accessibility without genuine time zone awareness limits real, timely communication.
- **Complaints are received but resolution isn't consistently communicated back to the family in a form they'd understand.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current complaint channel for genuine remote, language, and time zone accessibility.
Week 2	Establish or strengthen remote-accessible complaint intake in relevant languages.

When	What
Week 3	Establish documented resolution tracking with clear communication back to the family.
Ongoing	Track response times and resolution rates for international family complaints specifically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Complaint channel accessibility review	Reviews whether the complaint channel is genuinely reachable and usable from abroad.
DOCUMENT	Language and time zone accessibility review	Reviews whether the channel accounts for relevant languages and time zone differences.
DOCUMENT	Resolution record review	Reviews documented evidence that complaints from international families are genuinely addressed.

SUPERVISOR TIPS

- **Ask for a real example of a complaint received from a family abroad.** — A real example reveals whether the channel genuinely functions for exactly the families who need it most.
- **Test the complaint channel's accessibility in a language other than the local one.** — This directly reveals genuine language accessibility, not an assumption of it.

EVIDENCE BASE

[41] Cross-border patient and family redress mechanisms are identified in international medical travel governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international families face.

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.

8.7 Placement Facilitator and Agent Verification

Any placement facilitator or agent referring families to this facility is specifically verified — real business registration, a real, checkable track record — with the verification documented, not accepted based on the volume of placements they refer or how professional their marketing appears.

In plain terms: Any agency or facilitator that refers families to the home is checked — legal registration, track record — and the check is documented.

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

WHY THIS MATTERS

International placement agencies range from professional and ethical to predatory: charging families large fees for referrals, promising care the home cannot deliver, taking undisclosed commissions. A family abroad trusts the agent as their eyes and ears. If the agent lies, the home takes the blame. Verification: legal registration checked; references from other homes; a signed agreement on what they may promise, commission disclosure, and termination. A home that accepts referrals from anyone has no control over what families were told.

WHAT GOOD LOOKS LIKE

- Each facilitator is specifically verified for legitimate registration and track record.
- Verification is documented and periodically reconfirmed.
- A specific process reviews what facilitators actually represent to families.

COMMON FAILURE MODES

- Facilitators are accepted based on referral volume without specific verification.
- Verification, if it happened, was never reconfirmed after initial acceptance.
- No process exists to review what facilitators actually tell families.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home receiving referrals from four international placement agencies.

BEFORE

Agencies were engaged informally. One was found to have charged a family a €5,000 'placement fee' and promised a private room with en-suite that the home did not have. The home had no agreement with any agency and had never verified their registration.

ACTION

An agency verification standard was written: legal registration confirmed; two references from other homes; a signed agreement covering permitted representations, full disclosure of any fees to families, no undisclosed commissions, and termination for breach. All four agencies were reviewed; one was terminated. Families are sent the home's own information pack directly.

AFTER

The Monitor reviewed three agency files with verification and signed agreements. Interviewed a family who confirmed receiving the home's pack directly and knowing the agency's fee. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every agency that refers families to you.
2. Verify each one's registration and get two references.
3. Sign a one-page agreement on representations and fees.
4. Send families your own information pack directly.

The most common mistake: Trusting an agency because it sends good referrals — the families who were misled do not come.

SELF-ASSESSMENT QUESTIONS

1. Is each placement facilitator or agent specifically verified for legitimate business registration and a checkable track record? — *Genuine, specific verification, not accepted based on referral volume or*

marketing professionalism alone.

Evidence: Facilitator verification record

2. Is verification documented and periodically reconfirmed, not done once and assumed to remain valid indefinitely? — *An active, periodically reconfirmed process, not a one-time check.*

Evidence: Periodic reconfirmation record

3. Is there a specific process for reviewing what a facilitator actually tells families about this facility? — *Active oversight of facilitator representations, not an assumption they accurately represent the facility.*

Evidence: Facilitator representation review process

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens for new facilitator relationships but isn't reconfirmed for long-standing ones.** — A facilitator's legitimacy and practices can change over time even after an initial, valid verification.
- **Verification covers business registration but not the accuracy of their family-facing representations.** — A legitimately registered facilitator can still misrepresent care quality or conditions to families.
- **Families occasionally arrive with expectations that don't match what the facility actually offers.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current facilitator relationships for specific verification versus assumed legitimacy.
Week 2	Establish or strengthen documented verification for every facilitator relationship.
Week 3	Build a periodic reconfirmation schedule and a process for reviewing facilitator representations.
Ongoing	Review family expectations against facility reality as an indicator of facilitator accuracy.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Facilitator verification review	Reviews verification records for business registration and track record for each facilitator.

Method	What	Detail
DOCUMENT	Reconfirmation schedule review	Reviews whether verification is periodically reconfirmed, not a one-time check.
ASK	Representation review interview	Asks staff how they review what facilitators actually tell families about the facility.

SUPERVISOR TIPS

- **Ask for the actual verification record for a specific, named facilitator.** — A specific, documented record is the real evidence of genuine verification, not assumed legitimacy.
- **Ask a recent international family what they were told by their facilitator before placement.** — This reveals whether facilitator representations actually match facility reality.

EVIDENCE BASE

[42] Medical and long-term care placement governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the clinical quality of the receiving facility itself.

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.

8.8 Repatriation and End-of-Life Planning Across Borders Is Discussed in Advance

NON-NEGOTIABLE

For every international resident, the facility proactively discusses repatriation options and requirements with the family in advance — the documentation, timeline, and process required to return remains to the resident's home country, should death occur — not a conversation that first happens in the acute distress of an actual death.

In plain terms: For every international resident, the home discusses repatriation and end-of-life wishes with the family in advance — return home alive, return home after death, or remain — and knows the requirements.

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

WHY THIS MATTERS

When an international resident dies, the family faces a question in the worst moment: bring the body home, or bury here? Repatriation of remains requires embalming, documentation, consular involvement, and days of logistics — and costs thousands. If the family has not decided in advance, the decision is made in grief and haste, often badly. Similarly, if the resident's condition deteriorates and the family wishes to bring them home alive, that must be planned while transport is still possible. The home should raise this early, document the family's wishes, and know the practical requirements.

WHAT GOOD LOOKS LIKE

- Repatriation is proactively discussed with every international family in advance.
- Staff have specific, current knowledge of the relevant country's requirements.
- A specific support contact is available to help the family through the process.

COMMON FAILURE MODES

- Repatriation is first discussed only after a death has already occurred.
- Staff have only generic awareness, without specific, current country knowledge.
- No specific support exists to help the family navigate the actual process.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home where the death of an international resident had caused a crisis.

BEFORE

The question of repatriation had never been raised. When a resident died, the family — in another country — did not know the options, the cost, or the process. The body was held in the

	mortuary for 12 days while the family, the consulate, and a funeral director tried to arrange transport. The home did not know who to call.
ACTION	Repatriation and end-of-life planning is now part of the international admission process: the family's wishes for return home if the resident deteriorates, and for the body after death; the practical requirements (obtained from the consulate and an international funeral director); the estimated cost; the documentation the home will provide. This is documented in the advance care plan and reviewed annually. A relationship with an international funeral director was established.
AFTER	The Monitor reviewed 12 international residents' advance care plans with repatriation wishes documented, the consular requirement documents, and the funeral director agreement. One subsequent death was repatriated within four days. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For each international resident, ask: do we know what the family wants to happen after death?
2. Contact the relevant consulates for repatriation requirements.
3. Add repatriation wishes to the advance care planning conversation.
4. Find an international funeral director.

The most common mistake: Waiting until death to ask a family abroad what they want — it is the worst possible moment.

SELF-ASSESSMENT QUESTIONS

1. Does the facility proactively discuss repatriation options with the family in advance, not only after a death occurs? — *A genuine, proactive conversation held calmly in advance, not first raised during acute grief.*

Evidence: Advance repatriation discussion record

2. Does the facility have genuine, current knowledge of the specific documentation and process required for this resident's home country? — *Specific, current, country-relevant knowledge, not generic awareness that repatriation exists.*

Evidence: N/A — tested directly

3. Is there a specific point of contact to support the family through the actual repatriation process, if needed? — *A real, known support contact, not an assumption the family will navigate this alone.*

Evidence: Repatriation support contact protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **The conversation happens at admission but isn't revisited even after a significant health decline.** — A conversation held once, long before it may become relevant, may need genuine revisiting as circumstances change.
- **General awareness of repatriation exists but specific requirements aren't confirmed for the resident's actual home country.** — Requirements genuinely vary by country, and generic awareness isn't the same as accurate, specific knowledge.
- **A support contact exists but isn't clearly communicated to the family until it's actually needed.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for repatriation discussion timing — proactive versus reactive.
Week 2	Build country-specific repatriation information for common resident countries of origin.
Week 3	Establish and communicate a specific support contact for repatriation assistance.
Ongoing	Revisit repatriation planning after any significant change in resident health status.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Advance discussion record review	Reviews documentation of proactive repatriation conversations held with international families in advance.

Method	What	Detail
ASK	Country-specific knowledge interview	Asks staff about the specific repatriation requirements for a particular resident's home country.
DOCUMENT	Support contact review	Reviews the specific point of contact available to support a family through repatriation if needed.

SUPERVISOR TIPS

- **Ask whether repatriation has ever been discussed with a family before it became urgently relevant.** — A real, proactive example reveals genuine practice, not reactive crisis response.
- **Ask staff what specific documents are required to repatriate remains to a particular country.** — A specific, accurate answer reveals genuine, current knowledge, not generic awareness.

EVIDENCE BASE

[43] Established international consular practice recognizes that repatriation of remains across borders requires specific documentation, commonly including a mortuary or transit certificate and an authenticated local death certificate, coordinated between local authorities, the relevant embassy or consulate, and funeral directors in both countries.

[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.

8.9 Cultural and Dietary Continuity for the International Resident

CORE

An international resident's cultural, religious, and dietary practices from their country of origin are genuinely learned and accommodated on an ongoing basis — not assumed to be the same as, or expected to adapt to, the facility's local cultural default.

In plain terms: An international resident's food, faith, and daily customs from home are learned at admission and genuinely accommodated — not replaced with the local norm.

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

WHY THIS MATTERS

This is 3.4 with the added distance of another country: a resident who has moved not just from her home but from her homeland, to a place where the food, the language, the faith, and the customs are all foreign. The home cannot recreate her country, but it can learn what mattered — the morning tea prepared a particular way, the Friday prayer, the festival meal, the music — and provide it. The family, who chose this home from abroad, needs to see that their mother's identity has not been erased.

WHAT GOOD LOOKS LIKE

- The resident's own cultural, religious, and dietary practices are genuinely learned.
- Practices are genuinely accommodated on an ongoing basis.
- Genuine opportunity exists for cultural connection, not isolation.

COMMON FAILURE MODES

- Practices are assumed to match the facility's local default without genuine inquiry.
- Practices are noted at admission but not reflected in ongoing daily care.
- No opportunity exists for the resident to maintain cultural connection.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home with residents from four countries.

BEFORE

International residents received the local diet and local activities. A Turkish resident who had cooked for her family for 60 years ate almost nothing of the local food. A Japanese resident's family brought food weekly because the home

	offered nothing familiar. Faith practices were not accommodated.
ACTION	A cultural continuity assessment at admission, with the family, covers food (specific dishes, preparation, meal times), faith (practices, holy days, dietary laws), daily customs, music, and language. The kitchen prepares at least two familiar dishes a week per international resident, with recipes from the family. Faith practices are accommodated with local faith communities engaged. Cultural holidays are marked. Music and media from home are provided.
AFTER	The Monitor reviewed six cultural assessments and matching care plan adaptations, the kitchen's international menu rotation, and interviewed the Turkish resident who described 'eating properly again.' Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask each international resident's family: what three things from home would matter most?
2. Get recipes from families and put two familiar dishes a week on the menu.
3. Find the local faith community for each resident's tradition.
4. Mark each resident's cultural holidays.

The most common mistake: Assuming an elderly person will adapt to a new country's food and customs — they will not; they will decline.

SELF-ASSESSMENT QUESTIONS

1. Are the resident's own cultural, religious, and dietary practices from their country of origin genuinely learned? — *Specific, genuine effort to learn this resident's actual practices, not an assumption of local default.*

Evidence: Cultural and dietary preference documentation

2. Are these practices genuinely accommodated on an ongoing basis, not just noted at admission? — *Real, ongoing accommodation,*

not documentation without follow-through.

Evidence: N/A — tested directly

3. Does the resident have any way to maintain connection to their own cultural community, not only facility-local culture? — *Genuine connection opportunity, not isolation from their own cultural background.*

Evidence: Cultural connection support documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Dietary practices are accommodated but religious observance is less consistently supported.** — Genuine cultural continuity spans more than diet alone for most residents.
- **Accommodation is strong initially but drifts toward facility-local default over time.** — Ongoing accommodation needs genuine, sustained attention, not only initial effort.
- **Practices are respected individually but no broader opportunity exists to connect with others sharing this background.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current cultural and dietary accommodation for genuine, specific learning versus assumed default.
Week 2	Establish ongoing accommodation practice reflecting the resident's actual, documented preferences.
Week 3	Explore opportunities for the resident to maintain connection to their own cultural background.
Ongoing	Revisit cultural and dietary accommodation to confirm it hasn't drifted toward local default.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Preference learning review	Reviews evidence that the resident's own cultural and dietary practices were genuinely learned.
OBSERVE	Ongoing accommodation observation	Observes whether documented preferences are genuinely reflected in daily practice.

Method	What	Detail
DOCUMENT	Cultural connection review	Reviews what genuine opportunity exists for the resident to maintain connection to their own cultural background.

SUPERVISOR TIPS

- **Ask a resident or family member whether cultural and dietary practices genuinely feel respected.** — This tests lived experience, not documentation alone.
- **Compare documented preferences against what's actually provided in daily practice.** — This reveals whether accommodation is genuine and ongoing, not a one-time admission note.

EVIDENCE BASE

[44] Genuine accommodation of an international resident's own cultural, religious, and dietary practices, distinct from an assumption of adaptation to the facility's local default, is established practice in cross-cultural long-term care literature for supporting resident dignity and quality of life.

[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.

8.10 Time Zone and Distance-Adapted Family Communication CORE

Communication with an international family — scheduled calls, video visits, updates — is genuinely adapted to their actual time zone and circumstances, not offered only during the facility's own local convenient hours regardless of what time it is for the family.

In plain terms: Calls, video visits, and updates with families abroad are scheduled for their time zone and their circumstances — not when it is convenient for the home.

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

WHY THIS MATTERS

A family in Tokyo receiving a 2pm call from a home in Lisbon is receiving it at 10pm. A family working night shifts, or with young children, or in a country with unreliable internet, cannot join a video call scheduled for the home's morning. Adapted communication means: the family's time zone recorded; calls scheduled in their working day or at a time they choose; written updates sent at a time they will see them; video call technology that works in their country; and flexibility when their circumstances change. It costs the home nothing but thought.

WHAT GOOD LOOKS LIKE

- Communication scheduling genuinely accounts for the family's actual time zone.
- Video visits and calls are offered at realistically workable times.
- Families report genuine satisfaction with staying connected.

COMMON FAILURE MODES

- Communication is offered only during the facility's own convenient local hours.
- Video visit timing is impractical for the family's actual time zone.
- Families describe staying connected as a persistent, unresolved struggle.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home with families in five time zones.

BEFORE

The home called families during its own office hours. Families in Asia and the Americas received calls at night or early morning. Video calls were scheduled at the home's convenience; attendance was poor. Families complained they could never reach staff at a time that worked for them.

ACTION

Each international resident's file records the family's time zone, preferred contact hours, and preferred technology. Calls are scheduled within

the family's working day. Video calls are booked by the family through a scheduling link with slots covering all time zones, staffed by the evening and night shift where needed. Written updates are sent at 8am in the family's time zone. Emergency contact protocols specify calling regardless of time.

AFTER

The Monitor reviewed 12 files with time zone and preference records, the scheduling system with multi-time-zone slots, and video call attendance (up from 40% to 90%). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For each international family, write down their time zone and preferred contact hours.
2. Schedule routine calls in their working day.
3. Offer video call slots covering their time zones.
4. Send written updates to arrive in their morning.

The most common mistake: Calling when it suits the home — for a family twelve hours away, that is the middle of the night.

SELF-ASSESSMENT QUESTIONS

1. Is scheduled family communication genuinely adapted to the family's actual time zone, not only the facility's convenient hours? — *Real, practical accommodation of the family's actual circumstances, not one-sided scheduling.*

Evidence: Time zone-adapted communication schedule

2. Are video visits or calls genuinely offered at times realistically workable for the family? — *Real, workable timing, not options that technically exist but are impractical for the family to use.*

Evidence: N/A — tested directly

3. Does the family report genuine satisfaction with their ability to stay connected, not describe it as a persistent struggle? — *Real, reported satisfaction, not communication that technically exists but functions poorly in practice.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Scheduling accommodates time zone for planned calls but not for spontaneous updates.** — Genuine accommodation benefits both planned and unplanned communication moments.
- **Time zone adaptation happens for major care conferences but not for routine check-ins.** — Routine connection matters to a family too, not only major decision-point conversations.
- **Options exist but aren't proactively offered, leaving the family to request accommodation themselves.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current family communication scheduling for genuine time zone accommodation.
Week 2	Establish a standard practice of proactively offering time zone-appropriate options.
Week 3	Extend time zone accommodation to routine, not only major, communication.
Ongoing	Gather family feedback on genuine satisfaction with staying connected.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Communication schedule review	Reviews whether family communication scheduling genuinely accounts for time zone difference.
OBSERVE	Video visit timing observation	Checks whether video visit options are genuinely offered at workable times for the family.
ASK	Family satisfaction interview	Asks an international family about their genuine experience staying connected.

SUPERVISOR TIPS

- **Ask an international family directly whether communication timing genuinely works for them.** — This tests lived experience, not scheduling policy alone.

- **Ask staff how they'd schedule a call with a family many time zones away.** — A specific, thoughtful answer reveals genuine practice, not an assumption it's handled adequately.

EVIDENCE BASE

[45] Distance and time zone adaptation in family communication, distinct from communication offered only at the facility's own local convenience, is established practice in international long-term care family engagement for maintaining genuine, sustainable connection.

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 7 — Governance & Staffing**

Standard 9 — Health & Migration →

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