

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 9

Standard 9 — Health & Migration

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

CRITERIA IN THIS STANDARD

**9.1 — People-Centred Care
Adapted to Migration and
Displacement Experience**

**9.2 — Supporting Resident
Agency Through Genuine
Understanding of Care and the
Facility**

**9.3 — Language and
Communication Aids —
Interpreters and Cultural
Mediators**

**9.4 — Collaborative Practice
Across Health and Social
Services**

**9.5 — Trauma Resurfacing With
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**9.6 — Evidence-Informed Care
for Refugee and Migrant Elderly
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**9.7 — Staff Reflective Practice,
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in Migration Contexts**

**9.8 — Legal Status Diversity
Recognition**

**9.9 — End-of-Life Planning
Honours the Resident's Culture
When Return Home Isn't
Possible**

**9.10 — Care Is Documented and
Provided Regardless of
Immigration or Legal Status**

9.1 People-Centred Care Adapted to Migration and Displacement Experience

NON-NEGOTIABLE

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

In plain terms: Care is genuinely adapted for refugee and migrant residents — recognising trauma, legal-status fears, and the barriers they face — not just delivered the same way as for everyone else.

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

WHY THIS MATTERS

A refugee who has crossed a border on foot, lost family, and now fears deportation does not arrive at the care home as an ordinary resident. They may not disclose symptoms that could mark them as a burden. They may not return for follow-up because they moved or because the last clinic reported them. They may react to a physical examination with terror rooted in what was done to them before. Trauma-informed care means staff understand this, explain before touching, ask permission, avoid triggering procedures where possible, and never threaten legal consequences. It means the care home has decided that a person's migration status does not change their right to care — and staff know it.

WHAT GOOD LOOKS LIKE

- Care is genuinely, visibly adapted to migration and displacement history.
- Trauma-informed practice is actually applied, not just referenced.

COMMON FAILURE MODES

- Care is delivered identically regardless of migration history.
- Trauma-informed practice exists only as a stated principle, not applied practice.

- Staff demonstrate specific awareness of legal-status access barriers.

- Staff show no specific awareness of legal-status barriers.

WORKED EXAMPLE

IN PRACTICE

A 70-bed care home in a city with a large refugee population.

BEFORE

Refugee residents were treated identically to others. Staff had no training on trauma or migration. The Coordinator observed a nurse insisting a woman remove her headscarf for a routine examination, and a receptionist asking for immigration documents at registration. Refugee residents reported avoiding the care home because 'they ask questions.'

ACTION

A half-day trauma-informed care module was delivered to all resident-facing staff, developed with a refugee support NGO. A written policy stated that immigration status is not asked and does not affect care. Registration was simplified to name, date of birth, and contact. Examination consent scripts were adapted. A refugee liaison worker was engaged part-time through the NGO.

AFTER

The Monitor reviewed the policy, training records (94% of staff), and interviewed the liaison worker and two refugee residents who described feeling safe. Observed a consultation where the clinician explained each step before touching. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask refugee-serving organisations in your area what their clients say about your care home.
2. Write one sentence: 'We do not ask immigration status and it does not affect care.' Post it.
3. Arrange trauma-informed care training with an NGO that knows the population.
4. Remove immigration document requests from registration.

The most common mistake: Believing that treating everyone 'the same' is equity — for a traumatised resident, the same treatment is a different experience.

SELF-ASSESSMENT QUESTIONS

1. Is care genuinely adapted to a resident's migration and displacement experience, not delivered identically regardless of history? — *Genuine adaptation, not a generic cultural-awareness statement.*

Evidence: Training record on migration-adapted care

2. Is trauma-informed practice genuinely applied, not just referenced as a principle? — *Actual practice adaptation, not an assumption of general sensitivity.*

Evidence: N/A — tested directly

3. Are staff aware of legal-status barriers to access that may affect this specific resident? — *Specific awareness, not a general sense that barriers can exist.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Adaptation happens for residents who disclose their history but isn't proactively considered otherwise.** — Not every resident will volunteer this history unprompted, even when it is clinically relevant.
- **Staff are aware of the principle but haven't received specific training on applying it.** — General awareness doesn't reliably translate into genuine practice adaptation without specific training.
- **Adaptation is strong at admission but isn't sustained as staff turn over during a resident's long-term stay.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine adaptation to migration and displacement history.
Week 2	Train staff specifically on trauma-informed, migration-adapted practice.
Week 3	Build awareness of legal-status access barriers into standard practice.

When	What
Ongoing	Ensure new staff are briefed on a resident's migration history as part of onboarding to their care.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Migration-adapted care interview	Asks staff how they adapt practice specifically for a resident's migration and displacement history.
OBSERVE	Trauma-informed practice observation	Observes daily care for genuine trauma-informed practice, not generic sensitivity.
DOCUMENT	Training content review	Reviews training materials for specific coverage of migration-adapted, trauma-informed care.

SUPERVISOR TIPS

- **Ask staff to describe a specific example of adapting care for a resident's migration history.** — A real, specific example reveals genuine practice, not familiarity with the principle.
- **Ask a newer staff member how they learned about a specific resident's migration background.** — This reveals whether this understanding genuinely persists through staff turnover.

EVIDENCE BASE

[46] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

[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.

9.2

Supporting Resident Agency Through Genuine Understanding of Care and the Facility

NON-NEGOTIABLE

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

In plain terms: Residents are helped to understand their own care and how the home works — where things are, who does what, how to ask — and you check they have understood, not just told them.

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

WHY THIS MATTERS

A resident who does not know who her nurse is, how to ask for pain relief, where the garden is, what the daily routine will be, or that she can refuse a bath, is a resident who cannot participate in her own life. For refugees and migrants, the unfamiliarity is doubled: the language, the culture of care, the institution itself. Genuine understanding means: an orientation on arrival, in the resident's language, repeated as needed; a simple guide in their room; staff who check understanding ('Can you tell me how to call for help?'); and re-orientation when things change. Telling is not teaching.

WHAT GOOD LOOKS LIKE

- Teach-back genuinely verifies understanding of both care and facility navigation.
- Concrete, translated navigation guidance is provided, not just general encouragement.

COMMON FAILURE MODES

- Understanding is assumed from a nod or silence, with no active verification.
- Residents understand their specific care but not how to navigate the facility or raise concerns.

- Plain language is used consistently, especially when working through an interpreter.

- Jargon is used routinely, straining both interpretation and comprehension.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home with several refugee residents unfamiliar with institutional care.

BEFORE

New residents were shown their room and left. Refugee residents with no experience of care homes did not know how to use the call bell, that meals were provided, that they could leave their room, or that they could refuse anything. One resident did not eat for two days because she did not know meals were included.

ACTION

An orientation protocol was written: on arrival, a nurse walks the resident through their room, the call bell, the bathroom, the dining room, the garden, the daily routine, who their key worker is, and their rights — in their language, with an interpreter. A pictorial guide is left in the room. On day two and day seven, the key worker checks understanding with specific questions and re-explains. For residents with cognitive impairment, orientation is repeated daily.

AFTER

The Monitor reviewed 15 orientation records with documented understanding checks. Asked three refugee residents how to call for help and what happens at mealtimes; all answered correctly. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three new residents: 'How do you call for help? When is lunch? Who is your nurse?'
2. Write an orientation checklist and do it with an interpreter.
3. Leave a pictorial guide in the room.

4. Check understanding on day two and day seven.

The most common mistake: Showing a resident their room and assuming they know how a care home works.

SELF-ASSESSMENT QUESTIONS

1. Is understanding actively checked using a teach-back approach, for both the care plan and how the facility works, not assumed from a nod? — *Asking the resident to explain both back in their own words, not just asking "do you understand?"*

Evidence: N/A — tested directly

2. Is concrete, practical guidance provided on navigating this facility specifically — daily routines, how to raise a concern, activities available? — *Real navigation guidance, not just general encouragement.*

Evidence: Navigation guidance material

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

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Teach-back is used for major care decisions but not extended to facility-navigation information.** — Understanding how to actually live within the facility matters as much as understanding the immediate care plan.
- **Navigation support is given verbally at admission but not reinforced with anything the resident can review later.** — Complex facility information delivered once, verbally, under stress is easily forgotten, especially over a long residency.
- **Staff assume understanding for residents who have lived at the facility longer, missing gaps that may still exist.**

IMPLEMENTATION PLAN

When	What
Week 1	Observe current practice for both understanding-verification and facility-navigation support.
Week 2	Train staff on teach-back technique and develop translated navigation guidance.

When	What
Week 3	Brief staff to proactively cover facility navigation alongside the immediate care matter.
Ongoing	Spot-check resident understanding of both care and navigation periodically throughout their stay.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Teach-back practice observation	Observes a care conversation, or a simulated scenario, to check whether teach-back genuinely verifies understanding of both care and facility navigation.
DOCUMENT	Navigation material review	Reviews any materials or guidance provided on navigating the facility, in relevant languages.
ASK	Resident understanding check	Asks a resident to explain back their care and how they would raise a concern or request something.

SUPERVISOR TIPS

- **Observe an actual care conversation, watching specifically for teach-back covering both care and navigation.** — This is a practice that is easy to describe in policy and easy to skip under time pressure.
- **Ask a longer-term resident directly what they understand about raising a concern.** — This tests actual understanding sustained over time, not just satisfaction with an early conversation.

EVIDENCE BASE

[47] WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

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.

9.3 Language and Communication Aids — Interpreters and Cultural Mediators

NON-NEGOTIABLE

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

In plain terms: Trained interpreters or cultural mediators are used for language-discordant consultations — never children, and family members only when there is truly no alternative.

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

WHY THIS MATTERS

This is the refugee-specific counterpart of 8.3, and the stakes are higher. Refugee residents may be discussing torture, sexual violence, or mental illness — topics a family member cannot interpret and should not hear. A cultural mediator adds what an interpreter cannot: understanding of why a resident from a particular background may refuse a male examiner, may not disclose a symptom, or may interpret a question as a threat. Children must never interpret for parents: it exposes them to adult content, it distorts the information, and it places the child in an impossible position. Where the care home serves a refugee population, interpreter and mediator access is a core service, not an extra.

WHAT GOOD LOOKS LIKE

- Trained interpreters or cultural mediators are the default for language-discordant care, ongoing not just at admission.
- Staff confirm, without hesitation, that minors are

COMMON FAILURE MODES

- Ad hoc bilingual staff or family members are the default, with trained interpreters rarely engaged.
- A minor has been used to interpret, even

never used to interpret.

- Family-member interpretation, when it happens, is reserved for genuinely low-risk situations only.

occasionally.

- Family members interpret for high-risk situations like informed consent or bad news.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home serving a refugee settlement of 30,000 people.

BEFORE

Interpretation was by family members or other residents from the same language group. A ten-year-old was observed interpreting her mother's gynaecological consultation. A man was asked to interpret for a woman describing sexual violence. There was no interpreter budget and no mediator role.

ACTION

With NGO support, four cultural mediators from the main refugee language groups were recruited and trained. A phone interpretation service covered other languages. A written rule prohibited children interpreting and required same-gender interpreters for sensitive consultations. Interpreter and mediator use was documented. Staff were briefed on why family interpretation is unsafe.

AFTER

The Monitor reviewed 20 refugee resident records: interpreter or mediator documented in all language-discordant consultations. Observed a mediator-supported consultation. Interviewed a mediator who described the same-gender rule in practice. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask how the last ten refugee consultations were interpreted. Count how many used a child or a family member.
2. Write the rule today: no children; family only as a last resort and never for sensitive topics.

3. Recruit mediators from the main language groups — NGOs can help.
4. Contract a phone service for other languages.

The most common mistake: Using the resident's child to interpret because they speak the language best — the child is harmed and the information is distorted.

SELF-ASSESSMENT QUESTIONS

1. Are trained interpreters or cultural mediators engaged for language-discordant consultations and ongoing care? — *Not ad hoc bilingual staff or family members as the default, and not limited to admission alone.*

Evidence: Interpreter engagement record

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

Evidence: N/A — tested directly

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

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Trained interpreters are used at admission but family members fill in for routine, ongoing conversations.** — Ongoing care over a long residency carries the same real risk as the initial admission conversation.
- **The no-minors rule is understood by senior staff but not consistently reinforced with newer or part-time staff.** — A critical safeguard needs to be embedded in onboarding, not assumed as common knowledge.
- **Interpreter access exists during clinic hours but reverts to family members for urgent or after-hours situations.**

IMPLEMENTATION PLAN

When	What
Week 1	Review recent language-discordant care for interpreter engagement patterns across the full residency, not just admission.
Week 2	Establish or reinforce trained interpreter access, including for urgent and after-hours situations.
Week 3	Brief all staff explicitly and unambiguously that minors are never used to interpret.
Ongoing	Audit family-member interpretation instances to confirm they're confined to genuinely low-risk situations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Interpreter engagement review	Reviews records for evidence of trained interpreter or cultural mediator engagement across the resident's ongoing care.
ASK	Minor-interpreter policy check	Asks staff directly whether minors are ever used to interpret, and confirms understanding that this is never acceptable.
OBSERVE	High-risk situation check	Checks whether family-member interpretation, where it occurs, is confined to genuinely low-risk situations, never consent or bad news.

SUPERVISOR TIPS

- **Ask the minor-interpreter question directly and expect an immediate, confident answer.** — Any hesitation on this specific point is a serious signal worth investigating further.
- **Check interpreter coverage specifically for urgent or after-hours situations.** — This is where the policy is most likely to quietly lapse.

EVIDENCE BASE

[48] WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

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

9.4 Collaborative Practice Across Health and Social Services CORE

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

In plain terms: The care home works with legal, housing, education, and social services relevant to refugee residents — because their health depends on more than what happens in the care home.

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

WHY THIS MATTERS

A refugee child with malnutrition needs food, not just a prescription. A woman with chronic pain and a pending asylum claim needs legal support to reduce the stress that worsens the pain. A man with TB living in an overcrowded shelter needs housing to complete treatment. The care home cannot solve these problems, but it can connect residents to those who can — if it knows who they are. Collaborative practice means a directory of local services, referral pathways that actually work, and periodic contact between the care home and those services. It is the difference between treating symptoms and addressing causes.

WHAT GOOD LOOKS LIKE

- The facility actively, genuinely engages with

COMMON FAILURE MODES

- Care is treated in isolation from legal and social support factors.

relevant legal and social support services.

- Handover to other providers specifically includes migration-related context.
- Staff can name specific, current local services relevant to this population.

- Handover is generic, omitting migration-related context.
- Staff have no specific knowledge of relevant local services.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home in a region hosting refugees with no established links to social services.

BEFORE

Clinicians saw refugee residents with problems rooted in housing, legal status, and food insecurity, and had no one to refer to. A child with recurrent chest infections lived in a damp shelter; the paediatrician prescribed antibiotics repeatedly. No directory of services existed; no one had met the local refugee legal aid organisation.

ACTION

The Coordinator and the refugee liaison worker mapped local services: legal aid, housing support, food assistance, education, mental health. A one-page directory was created for clinicians. A quarterly meeting with the three main NGOs was established. Referral forms were created and tracked. The child's family was referred to housing support and rehoused.

AFTER

The Monitor reviewed the directory, meeting minutes from three quarters, and 25 tracked referrals with outcomes. Interviewed an NGO partner who described the working relationship. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the non-medical problems you see in refugee residents: housing, legal, food, education.

2. Find the organisations in your area that address each. Meet them.
3. Create a one-page directory for clinicians.
4. Track referrals and meet the organisations quarterly.

The most common mistake: Treating the medical consequence of a social problem repeatedly because no one has connected the resident to the service that could fix the cause.

SELF-ASSESSMENT QUESTIONS

1. Does the facility actively engage with relevant legal and social support services, not treat care in isolation? — *Genuine, active engagement, not a general awareness that such services exist.*
Evidence: Social services engagement record
2. Does handover to another provider specifically include migration- and displacement-related context? — *Specific inclusion of this context, not a generic handover.*
Evidence: N/A — tested directly
3. Are staff aware of specific local services relevant to this population, not just services generally? — *Specific, current knowledge, not a vague sense that support services exist somewhere.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Engagement happens with legal services but not consistently with broader community support.** — Each of these factors can independently and significantly affect a resident's wellbeing.
- **Handover includes clinical information but omits migration-related context that shaped the resident's care.**
- **Staff know general categories of support exist but not specific, current local contacts.**

IMPLEMENTATION PLAN

When	What
Week 1	Map current engagement with relevant legal and social support services.
Week 2	Establish or strengthen specific, current local service contacts.

When	What
Week 3	Build migration-related context into standard handover documentation.
Ongoing	Refresh knowledge of local services periodically as availability changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Social services engagement review	Reviews evidence of active engagement with relevant social and legal support services.
DOCUMENT	Handover content review	Reviews handover documentation for specific inclusion of migration-related context.
ASK	Local services knowledge interview	Asks staff to name specific local services relevant to refugee and migrant residents.

SUPERVISOR TIPS

- **Ask staff to name a specific local service they would refer a resident's family to, not a general category.** — Specificity reveals genuine, current knowledge rather than assumed awareness.
- **Review a real handover document for migration-related context inclusion.** — A real example reveals whether this happens in practice, not just in policy.

EVIDENCE BASE

[49] WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

[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.

9.5 Trauma Resurfacing With Cognitive Decline Is Recognised and Addressed

Staff are trained to recognise that the onset or progression of dementia can trigger the re-emergence of traumatic stress symptoms dormant for decades — particularly among refugee and displaced residents — with a resident's known life history actively used to understand and respond to these symptoms, not treated as unrelated behavioral decline.

In plain terms: Staff know that dementia can bring back old trauma — war, persecution, flight — and are trained to recognise and respond when a refugee resident relives it.

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

WHY THIS MATTERS

A refugee who fled violence decades ago, built a life, and suppressed the memories, may find them returning as dementia erodes the defences. She hears the fire alarm and is back in the bombardment. He sees a uniformed staff member and is back in the camp. She resists being undressed because she was once stripped by soldiers. Staff who do not know this see 'agitation' and reach for sedation. Staff who know it recognise the trauma, understand the trigger, and respond with safety, calm, and the person's life story (5.5). Training must be specific: what trauma re-emergence looks like, what triggers to anticipate, how to respond.

WHAT GOOD LOOKS LIKE

- Staff are specifically trained on trauma re-emergence in dementia, not general behavior training alone.
- Known trauma history and life story genuinely inform individual care response.
- Standard care practices are specifically reviewed for retraumatising

COMMON FAILURE MODES

- Trauma re-emergence is not distinguished from general dementia-related behavioral change.
- Known history isn't connected to actual care planning or symptom response.
- Standard care practices are applied uniformly without considering

potential for residents with known trauma history.

individual retraumatising risk.

WORKED EXAMPLE

IN PRACTICE

A 40-bed dementia unit with several residents who had survived war and displacement.

BEFORE

A resident who had survived a massacre became terrified during fire drills and was sedated. Another, a former political prisoner, fought staff who tried to help him wash and was labelled aggressive. Staff had no idea of the residents' histories and no training on trauma in dementia.

ACTION

Life stories (5.5) were gathered with specific attention to traumatic history, with family help and sensitivity. Staff received training from a psychologist experienced in refugee trauma: how trauma re-emerges in dementia, recognising signs, anticipating triggers, and responding (safety, calm, familiar voice, no force). Care plans record known triggers and effective responses. The fire drill protocol was adapted for the massacre survivor (advance warning, a trusted staff member with her). Washing for the former prisoner is done by one consistent staff member, with explanation, at his pace.

AFTER

The Monitor reviewed six care plans with trauma histories, triggers, and responses; training records; and observed the adapted approach with one resident. Sedation for both residents had stopped. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask the families of refugee residents, gently, about traumatic history.
2. Record known triggers in the care plan.
3. Train staff on trauma re-emergence in dementia.

4. Adapt routines — fire drills, personal care — for residents with known triggers.

The most common mistake: Seeing a resident's terror during a fire drill as dementia-related agitation — it may be a memory of being bombed.

SELF-ASSESSMENT QUESTIONS

1. Are staff trained that dementia can trigger re-emergence of dormant trauma symptoms, particularly for refugees? — *Specific training on this phenomenon, not general dementia training alone.*

Evidence: Trauma-dementia training record

2. Is a resident's known trauma history actively used to understand specific symptoms or triggers? — *Genuine application of known history, not care disconnected from it.*

Evidence: Life history and trauma-informed care plan

3. Are care practices — bathing, personal care, restricted movement — reviewed for retraumatizing potential? — *Specific, individual review, not a generic assumption.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Staff recognise the general concept but don't consistently apply it to specific behavioral episodes.** — General awareness needs to translate into genuine, individual application during real moments of distress.
- **Life history is documented but not actively referenced during care planning or in-the-moment response.** — Documented history that isn't genuinely used provides limited real protective value.
- **Awareness is strong among nursing staff but not consistently shared with support staff providing daily personal care.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current staff awareness of trauma re-emergence as distinct from general dementia behavior.

When	What
Week 2	Train staff specifically on this documented phenomenon and how life history informs response.
Week 3	Review standard care practices for individual retraumatising potential for residents with known trauma history.
Ongoing	Revisit trauma-informed care planning as a resident's dementia progresses.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Training review	Reviews training content for specific coverage of trauma re-emergence in dementia, distinct from general dementia training.
DOCUMENT	Life history application review	Reviews whether known trauma history genuinely informs a resident's individual care plan and response to symptoms.
ASK	Care practice review interview	Asks staff whether standard care practices have been specifically reviewed for retraumatising potential for a resident with known trauma history.

SUPERVISOR TIPS

- **Ask staff to describe a specific example of connecting a resident's life history to a behavioral episode.** — A real, specific example reveals genuine understanding, not familiarity with the general concept.
- **Ask how personal care practices, like bathing assistance, have been adapted for a resident with known trauma history.** — This tests whether the principle translates into genuine, practical care adaptation.

EVIDENCE BASE

[50] Nygren B, Hydén LC. Caring for older people with dementia reliving past trauma. *Nurs Ethics*. 2020;27(2):621-633 — documents that the onset of dementia can trigger the re-emergence of traumatic stress symptoms dormant for decades among genocide and violence survivors, and establishes that knowledge of a resident's life story enables staff to adapt care and avoid retraumatising triggers.

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

9.6 Evidence-Informed Care for Refugee and Migrant Elderly Residents CORE

Staff use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general elderly population, and identify where evidence gaps remain — not applying general geriatric guidelines uncritically to a population with documented, different health needs and risk factors.

In plain terms: Staff use evidence-based guidance for refugee and migrant elderly care where it exists, know where the evidence is thin, and adapt — instead of applying local norms without thought.

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

WHY THIS MATTERS

Elderly refugees have specific health profiles: higher rates of chronic conditions that went untreated, dental disease, hepatitis B, latent TB, nutritional deficiencies, and mental health consequences of trauma. They may have unfamiliar expectations of care, family roles, and end of life. Evidence-informed care means the home has looked for guidance — WHO, national refugee health frameworks, gerontology literature on migrant elderly — and applied it: screening for the conditions that are likely, care adapted to expectations, family involved as the culture expects. Where guidance does not exist, staff know that and think rather than default.

WHAT GOOD LOOKS LIKE

- Staff are aware of and use population-specific

COMMON FAILURE MODES

- General geriatric guidelines are applied

evidence-informed guidelines where they exist.

- Staff can describe specific, genuine differences in this population's health needs.
- Practice is genuinely adapted where population-specific evidence indicates it should be.

uncritically with no population-specific awareness.

- Staff cannot describe any specific way this population's needs differ.
- Awareness exists but doesn't translate into any actual practice adaptation.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home that had begun admitting elderly refugees.

BEFORE

Refugee residents received the standard admission assessment. Latent TB and hepatitis B were not screened. Family expectations of daily involvement in care were seen as interference. Staff were unaware of any specific guidance.

ACTION

The home obtained national refugee health guidance and gerontology resources on migrant elderly. The admission assessment for refugee residents added screening for TB, hepatitis, nutritional deficiencies, and dental disease; a mental health screen adapted for trauma; and a cultural care expectations conversation with the family. Family involvement in daily care is welcomed where the resident and family wish. A quarterly review with a refugee health specialist covers complex cases. The guidance is reviewed annually.

AFTER

The Monitor reviewed the adapted assessment, guidance sources, 10 refugee resident records with screening and findings (two latent TB, one hepatitis B treated), and the specialist review record. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find your national refugee health guidance and any resource on migrant elderly care.
2. Add relevant screening to the admission assessment for refugee residents.
3. Ask families what they expect their role in care to be.
4. Review complex cases with a specialist.

The most common mistake: Applying the standard admission assessment to an elderly refugee — the disease burden is different and invisible without screening.

SELF-ASSESSMENT QUESTIONS

1. Are staff aware of evidence-informed guidelines specific to refugee and migrant health where they exist? — *Specific, current awareness, not general geriatric knowledge assumed to be sufficient.*
Evidence: Guideline awareness record
2. Do staff recognise where this population's health needs genuinely differ from the general elderly population? — *Genuine, specific recognition — for example, elevated PTSD and chronic disease risk — not an assumption that general guidelines always apply equally.*
Evidence: N/A — tested directly
3. Is practice adapted where population-specific evidence indicates a different approach is warranted? — *Actual practice adaptation, not awareness without application.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Awareness exists for well-known differences but not for more specific or recent evidence.** — Evidence in this area continues to develop, and awareness needs to stay genuinely current.
- **Guidelines are known but not consistently applied under time pressure.** — Consistent application under real conditions is what gives awareness genuine protective value.
- **Evidence gaps are acknowledged but staff default to general population assumptions rather than flagging genuine uncertainty.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current awareness of population-specific evidence-informed guidelines.
Week 2	Establish access to current, relevant guidelines for staff.
Week 3	Train staff on specific, genuine population differences relevant to practice.
Ongoing	Refresh awareness as evidence in this area develops.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Guideline awareness review	Reviews whether staff have access to and awareness of population-specific evidence-informed guidelines.
ASK	Population-difference interview	Asks staff to describe a specific way this population's health needs differ from the general elderly population.
OBSERVE	Practice adaptation check	Checks whether practice genuinely reflects population-specific evidence where it exists.

SUPERVISOR TIPS

- **Ask staff for a specific example of a practice adaptation based on population-specific evidence.** — A real example reveals genuine application, not just familiarity with the concept.
- **Ask how staff would handle a genuine evidence gap for this population.** — A thoughtful, honest answer reveals genuine engagement rather than a default assumption.

EVIDENCE BASE

[51] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

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

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

NON-NEGOTIABLE

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

In plain terms: Staff actively reflect on their own biases and culture, the care home supports this through structured practice, and staff working with traumatised residents are looked after.

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

WHY THIS MATTERS

Every clinician has assumptions about people from other cultures, and most are unaware of them. The nurse who assumes a refugee is exaggerating pain, the doctor who is impatient with a resident who will not make eye contact, the receptionist who is curt with someone who does not understand the form — each is acting on bias, and each affects care. Reflective practice — structured time to examine one's reactions — reduces this. The second element is staff wellbeing: hearing accounts of torture and loss every day takes a toll, and staff who are burned out become staff who withdraw. Supervision, peer support, and access to counselling are not luxuries in a care home serving refugees.

WHAT GOOD LOOKS LIKE

- A structured reflective practice process

COMMON FAILURE MODES

- No structured reflective practice process exists

genuinely exists and is used, not just assumed.

- Genuine, accessible psychological support exists and staff actually use it.
- Staff can describe specific, real examples of both bias adaptation and vicarious trauma awareness.

beyond an assumption of individual self-awareness.

- Psychological support exists only nominally, with no evidence staff actually access it.
- Staff cannot describe any specific example of adapting practice or recognising vicarious trauma.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home where a third of residents are refugees.

BEFORE

No reflective practice existed. Staff complained about refugee residents in the break room; some described them as 'demanding.' A nurse who had heard multiple accounts of sexual violence had started avoiding female refugee residents. There was no supervision or support for staff exposed to trauma narratives.

ACTION

Monthly facilitated reflective practice sessions were introduced for clinical teams, led by a psychologist from a partner NGO, using real (anonymised) cases. An implicit bias workshop was run once for all staff. A peer support scheme was set up. Confidential counselling access was arranged through the NGO. Attendance was tracked.

AFTER

The Monitor reviewed session records (10 sessions, average 70% attendance), workshop records, and the counselling access agreement. Interviewed three staff who described the sessions as valuable and gave examples of changed practice. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Listen in the break room. What do staff say about refugee residents when they think no one is listening?
2. Arrange one implicit bias workshop with an NGO or university.
3. Start monthly reflective practice sessions with a facilitator.
4. Arrange confidential counselling access for staff.

The most common mistake: Training staff in cultural competence once and assuming bias is fixed — it is a practice, not a certificate.

SELF-ASSESSMENT QUESTIONS

1. Does the facility have a structured process for staff reflective practice regarding bias and cultural awareness? — *A defined process, not an assumption that staff will naturally self-reflect adequately.*
Evidence: Reflective practice process description

2. Does the facility provide genuine, accessible psychological support for staff working with residents who have severe trauma histories? — *Actual, used support, not a theoretical benefit or informal hope.*
Evidence: Psychological support access record

3. Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves or colleagues? — *Genuine, concrete examples, not general statements of good intentions or awareness.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Reflective practice happens informally among some staff but is not structured or facility-wide.** — Individual good practice does not reliably generalise without a defined, shared process.
- **Support exists but staff are unaware it is available or feel discouraged from using it.** — A benefit's existence does not guarantee genuine, comfortable access to it.
- **Support exists for acute incidents but not for the cumulative emotional weight of long-term care for trauma survivors.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current training content and support access for genuine coverage of bias and staff wellbeing.
Week 2	Establish a structured reflective practice process and strengthen support access.
Week 3	Deliver specific training on institutional discrimination and normalise use of available psychological support.
Ongoing	Revisit reflective practice and staff wellbeing periodically, using real case examples where appropriate.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Reflective practice process review	Reviews the facility's structured process, if any, for staff reflective practice on bias and cultural awareness.
DOCUMENT	Support access review	Reviews what psychological support genuinely exists and whether staff actually use it.
ASK	Staff example interview	Asks a staff member for a specific instance of recognising and adapting for their own bias, and how they process the emotional weight of this work.

SUPERVISOR TIPS

- **Ask for a specific personal example, not a general statement of awareness.** — A concrete instance distinguishes genuine reflective practice from familiarity with the concept.
- **Ask staff directly whether they have used available support, not just whether it exists.** — Genuine uptake, not nominal availability, is the real test.

EVIDENCE BASE

[52] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a

supportive team environment addressing the wellbeing impacts of migration-context care.

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

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

9.8 Legal Status Diversity Recognition

CORE

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

In plain terms: The care home can name which legal status groups it serves — asylum seekers, recognised refugees, stateless people, internally displaced, undocumented — and knows what each group is entitled to.

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

WHY THIS MATTERS

An asylum seeker in many countries is entitled to emergency care only. A recognised refugee has the same entitlements as citizens. A stateless person may have no entitlement at all under the letter of the law. An undocumented migrant may be entitled to nothing — or to everything, depending on the jurisdiction and the type of care. A care home that does not know these distinctions either turns away people who are entitled to care or treats people it cannot be reimbursed for without knowing it. Knowing the categories, the entitlements, and — critically — the care home's own policy on treating people regardless of entitlement is the foundation for consistent, fair, and legally defensible practice.

**WHAT GOOD LOOKS
LIKE**

**COMMON FAILURE
MODES**

- Staff can name the specific legal status categories this facility actually serves.
- Policy genuinely differentiates access and planning considerations across status categories.
- A specific, defined process exists for verifying unclear status.

- Staff have only a general sense that "migrants" are served, without specific categories.
- A single, uniform assumption about access rights and planning is applied regardless of status.
- No process exists for verifying status when it's genuinely unclear.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home in a country with five legal categories for displaced people and different entitlements for each.

BEFORE

Registration staff did not know the categories. Residents were sometimes turned away because 'refugees are not covered' when in fact they were. Others were treated and the care home could not claim reimbursement because the correct category was not recorded. The care home had no written position on treating people outside any entitlement.

ACTION

The Coordinator obtained the legal entitlements for each category from the Ministry and UNHCR. A one-page reference was created for registration staff. A care home policy stated: emergency care for everyone regardless of status; other care per entitlement; and a defined charity fund for those with no entitlement. Registration records the category (with the resident's consent) for reimbursement purposes only — it does not affect clinical care.

AFTER

The Monitor reviewed the entitlement reference, the policy, and 20 registration records with category correctly recorded. Interviewed two

registration staff who correctly described entitlements for three categories. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the legal status categories that exist in your country for displaced people.
2. Find out what each is entitled to — ask the Ministry or UNHCR.
3. Write a one-page reference for registration staff.
4. Decide and write down what you will do for people with no entitlement.

The most common mistake: Treating all displaced people as one category — 'refugees' — when the law treats them differently and the care home's obligations differ.

SELF-ASSESSMENT QUESTIONS

1. Can staff name the specific legal status categories this facility actually serves? — *Specific, named categories, not a general sense that "migrants" are served.*

Evidence: N/A — tested directly

2. Does the facility avoid applying a single, uniform assumption about access rights and future planning across all statuses? — *Genuine differentiation, not treating all categories identically.*

Evidence: Status-specific care and planning policy documentation

3. Is there a specific process for verifying which category applies when it's genuinely unclear? — *A real, defined process, not guesswork or assumption when status is ambiguous.*

Evidence: Status verification process

COMMON REASONS FOR A PARTIAL ANSWER

- **Staff can name the most common category served but not less frequent ones the facility still encounters.** — Even infrequent categories deserve genuine, specific awareness, not the risk of misapplied assumptions.
- **Differentiation exists in policy but isn't consistently applied by all staff in practice.** — A policy that exists on paper needs consistent application to provide real protection.
- **Status is understood for care access but not connected to longer-term planning implications.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current staff awareness of the specific legal status categories actually served.
Week 2	Build specific, differentiated guidance for each relevant status category, including planning implications.
Week 3	Establish a clear verification process for genuinely unclear status.
Ongoing	Refresh staff awareness periodically, particularly for less frequently encountered categories.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Status category awareness interview	Asks staff to name the specific legal status categories this facility actually serves.
DOCUMENT	Status-specific policy review	Reviews documentation for genuine differentiation across status categories, not a uniform assumption.
DOCUMENT	Verification process review	Reviews the process for verifying status when it's genuinely unclear.

SUPERVISOR TIPS

- **Ask staff to name every specific legal status category the facility has served recently.** — Specificity reveals genuine, current awareness rather than a general assumption.
- **Ask what happens when a resident's specific status is genuinely unclear.** — A confident, specific answer reveals a genuine process, not improvisation.

EVIDENCE BASE

[53] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

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

9.9 End-of-Life Planning Honours the Resident's Culture When Return Home Isn't Possible

NON-NEGOTIABLE

For a refugee or stateless resident who cannot return to their country of origin, even in death, end-of-life planning genuinely explores culturally and religiously appropriate alternatives — a local ceremony reflecting their tradition, connection with a diaspora community — not a default assumption that standard local practice is the only available option.

In plain terms: For a refugee or stateless resident who can never return to their homeland — even in death — the home explores what a culturally right end of life and burial looks like, with the resident and community.

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

WHY THIS MATTERS

A stateless resident has no country to be repatriated to. A refugee whose homeland is at war, or whose family was killed, or who fled persecution, may have no one and nowhere. When they die, the home's default — a local funeral, a local cemetery, local rites — may violate everything they believed. The home must ask, early: what does a good death and burial look like in your tradition? Who from your community should be involved? What rites, what direction, what timing, what food, what prayers? And then find the community — a faith leader, a cultural association, a diaspora group — who can make it happen. Dignity in death is the last thing the home can give.

WHAT GOOD LOOKS LIKE

- End-of-life planning genuinely explores

COMMON FAILURE MODES

- No alternative is explored beyond default local

meaningful, culturally appropriate alternatives.

- Genuine effort connects the resident with relevant diaspora or faith community where one exists.
- The conversation is held with genuine sensitivity to the resident's specific situation.

custom.

- No effort is made to identify or connect with a relevant diaspora or faith community.
- The conversation is generic, not adapted to the resident's specific, painful reality.

WORKED EXAMPLE

IN PRACTICE

A 50-bed care home with three stateless residents and no plan for their deaths.

BEFORE

The residents' end-of-life wishes had not been explored. One died and was buried by the local authority with no rites, no community, and no one present. The home did not know the resident's faith or that a local community of his background existed.

ACTION

For every refugee and stateless resident, the advance care planning conversation (6.1) now includes: faith and cultural end-of-life practices; wishes for burial or cremation; rites, timing, and direction; who should be involved; and whether a community from their background exists locally. The home contacted diaspora and faith organisations for each resident's tradition and recorded contacts. A fund was established for culturally appropriate funerals where residents have no means. One subsequent death was marked with the resident's tradition's rites, attended by 20 members of a community she had not known existed.

AFTER

The Monitor reviewed the advance care plans for refugee and stateless residents with end-of-life cultural wishes documented, the community

contact list, the funeral fund, and the record of the funeral. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For each refugee or stateless resident, ask: 'What would a good death and burial look like in your tradition?'
2. Find the faith leader or community organisation for their tradition.
3. Record the wishes and contacts in the advance care plan.
4. Establish a fund for residents with no means.

The most common mistake: Letting a stateless resident be buried by the local authority with no rites — the home could have found their community.

SELF-ASSESSMENT QUESTIONS

1. Does end-of-life planning genuinely explore culturally and religiously appropriate alternatives for a resident who cannot return home? — *Real, proactive exploration of meaningful alternatives, not silence or a default assumption.*

Evidence: Culturally adapted end-of-life planning documentation

2. Is there genuine effort to connect the resident with a relevant diaspora or faith community, where one exists? — *Real, active effort, not an assumption none exists or that it isn't the facility's role to help find one.*

Evidence: Community connection effort documentation

3. Is this conversation held with genuine sensitivity to why return isn't possible, not treated as a routine, generic discussion? — *Genuine sensitivity to the resident's specific, often painful situation, not a generic planning conversation.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The conversation happens but relies on the resident to raise it themselves rather than being proactively offered.** — A resident may not know to ask, or may find it too painful to raise unprompted, without the facility proactively offering the conversation.
- **Community connection is attempted but not genuinely pursued if initial contact doesn't succeed.** — A meaningful connection may

take real, sustained effort to establish, not a single attempted contact.

- **Planning happens for the resident but doesn't specifically involve family members who may also be displaced across multiple countries.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current end-of-life planning practice for residents unable to return to their country of origin.
Week 2	Build genuine, proactive practice for exploring culturally appropriate alternatives.
Week 3	Establish a genuine effort process for connecting with relevant diaspora or faith communities.
Ongoing	Revisit this planning as a resident's circumstances or wishes may change.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Culturally adapted planning review	Reviews end-of-life planning documentation for genuine exploration of appropriate alternatives.
DOCUMENT	Community connection review	Reviews evidence of genuine effort to connect the resident with relevant diaspora or faith community.
ASK	Conversation sensitivity interview	Asks staff how they approach this conversation with genuine sensitivity to the resident's situation.

SUPERVISOR TIPS

- **Ask staff for a real, specific example of this conversation and what alternatives were genuinely explored.** — A real example reveals whether this is genuine practice, not just policy language.
- **Ask how the facility would help connect a resident with a relevant community if none is already known.** — A specific, thoughtful answer reveals genuine, active effort, not passive assumption.

EVIDENCE BASE

[54] Genuine exploration of culturally and religiously appropriate end-of-life alternatives for residents unable to return to their country of origin, distinct from default application of local custom, is established practice in refugee and displaced-population end-of-life care literature.

[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.

9.10 Care Is Documented and Provided Regardless of Immigration or Legal Status

NON-NEGOTIABLE

Care is provided and fully documented for every resident regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to residents without documented status.

In plain terms: Every resident receives the same care and the same documentation regardless of immigration status — no lower standard, no incomplete record, no 'informal' arrangement.

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

WHY THIS MATTERS

This principle applies across every facility type and long-term care is no exception. An undocumented elderly resident cared for 'informally' has no record, no protection, and no continuity. A refugee given a lower standard because 'they won't complain' is a victim of discrimination in their home. The policy must be explicit: identical care, consent, documentation, and rights for every resident; status not asked at admission; funding handled separately and never as a barrier. Staff must know it and act on it.

**WHAT GOOD LOOKS
LIKE**

**COMMON FAILURE
MODES**

- Care and documentation are genuinely consistent regardless of status.
- Staff are specifically trained on this principle, not assumed to understand it.
- Confidentiality protection is applied equally without exception.

- Care or documentation practice differs based on a resident's known or assumed status.
- No specific training addresses this principle.
- Status-related information is handled less carefully than other confidential information.

WORKED EXAMPLE

IN PRACTICE

A 60-bed care home with two undocumented residents.

BEFORE

The two residents were cared for without a formal record because the home feared regulatory consequences. They were not on the resident register, had no care plan, and received no monthly weights or reviews. One developed a pressure injury that went unnoticed because she was not on the pressure injury audit list.

ACTION

A written policy: every resident is registered, assessed, planned, and documented identically regardless of status; immigration status is not asked; funding is handled by the administrator separately. The two residents were fully registered and assessed. The home's regulator was consulted and confirmed that care documentation is required regardless of status. A charity fund covers residents with no funding entitlement.

AFTER

The Monitor reviewed the policy and the two residents' now-complete records, and confirmed their inclusion in all audits. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask: is every person living here on the resident register with a care plan?

2. Write the one-sentence policy.
3. Register and assess anyone who is not.
4. Handle funding separately, after care.

The most common mistake: Keeping undocumented residents off the register to protect them — an unregistered resident is unprotected.

SELF-ASSESSMENT QUESTIONS

1. Is the same standard of care applied and documented the same way regardless of a resident's immigration or legal status? — *Genuinely equal treatment, not a lesser or informal standard for undocumented residents.*

Evidence: N/A — tested directly

2. Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation? — *Specific, documented training, not assumed understanding.*

Evidence: Staff training record

3. Is resident information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information? — *The same confidentiality protection extended to every resident, without exception.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The principle is understood by clinical staff but not consistently by administrative staff.** — A resident's first interaction is often with administrative staff, where the same principle needs to hold.
- **Care is consistent but documentation habits vary informally based on individual staff assumptions.** — Consistency needs to extend to documentation practice specifically, not only the clinical care itself.
- **The principle is followed but has never been specifically, formally trained.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for any differential treatment based on status.

When	What
Week 2	Establish specific staff training on this principle, covering all staff, not only clinical roles.
Week 3	Confirm documentation practice is genuinely consistent regardless of status.
Ongoing	Reinforce training periodically, particularly for new staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Care standard observation	Observes whether care and documentation practice is genuinely consistent regardless of resident status.
DOCUMENT	Staff training review	Reviews training records confirming staff understand immigration status is never a basis for differential care.
ASK	Confidentiality practice interview	Asks staff how resident status information, where known, is protected.

SUPERVISOR TIPS

- **Ask administrative staff, not only clinicians, about this principle.** — This reveals whether the principle genuinely extends beyond clinical staff.
- **Ask how resident status information, where it becomes known, is protected.** — A specific, confident answer reveals genuine practice, not just a stated value.

EVIDENCE BASE

[55] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

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 8 — Medical
Tourism

Standard 10 —
Rehabilitation →

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Standard 10 — Rehabilitation

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

CRITERIA IN THIS STANDARD

- 10.1 — Individualized Functional Maintenance Plan Based on Assessment
- 10.2 — Coordination Between Therapy and Daily Nursing Care
- 10.3 — Resident and Family Goal-Setting
- 10.4 — Function Tracked with Validated Tools, Decline Flagged Early
- 10.5 — Equipment and Assistive Device Provision Matches Need
- 10.6 — Restraint-Free and Least-Restrictive Mobility Support

10.1 Individualized Functional Maintenance Plan Based on Assessment

NON-NEGOTIABLE

Every resident receiving rehabilitation or restorative therapy has an individualized plan built from a documented functional assessment, oriented toward maintaining and slowing decline in function — not a generic protocol assuming an acute-recovery trajectory that doesn't fit a long-term care context.

In plain terms: Each resident’s rehabilitation plan is genuinely built around maintaining their actual function over time — not a hospital-style recovery protocol that assumes they’ll return to full baseline.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

An acute-recovery rehabilitation protocol, borrowed directly from a hospital setting, assumes a trajectory toward full functional recovery and eventual discharge — a framing that often doesn’t match the realistic goals of a long-term care resident, where maintaining current function or slowing an expected decline is frequently the genuinely appropriate target. Applying the wrong framework risks setting residents and families up for disappointment against an unrealistic recovery goal, or conversely, understating what maintenance therapy can genuinely achieve.

WHAT GOOD LOOKS LIKE

- A functional assessment specifically oriented to maintenance, not an assumed recovery trajectory.
- The plan is genuinely individualized, verifiable across several resident plans.
- The plan is reassessed on a defined schedule as function changes over the stay.

COMMON FAILURE MODES

- A hospital-style acute-recovery protocol is applied without adaptation to long-term care goals.
- Multiple resident plans read nearly identically, suggesting a template rather than individualization.
- A plan set at admission is never revisited over a long-term stay.

WORKED EXAMPLE

IN PRACTICE

A resident with progressive Parkinson’s disease receiving physical therapy.

BEFORE

The therapy plan was built using a standard acute-recovery template borrowed from the

	facility's hospital-affiliated rehab unit, with goals framed around regaining lost function, despite the resident's progressive condition meaning functional maintenance, not recovery, was the realistic target.
ACTION	The facility adopted a functional maintenance assessment framework specific to progressive and chronic conditions, explicitly distinct from acute recovery templates, with goals reframed around slowing decline and preserving independence in specific tasks.
AFTER	The Monitor reviewed the revised plan and found goals genuinely framed around maintenance and decline-prevention, with the resident's family confirming they understood this was the realistic goal. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether current therapy plans use an acute-recovery framework inappropriate to long-term care.
2. Build or adopt a functional maintenance assessment framework.
3. Compare several current resident plans to check for genuine individualization.

The most common mistake: Applying a standard acute-recovery rehabilitation framework, often borrowed from an affiliated hospital unit, without adapting it to the genuinely different goal of functional maintenance that fits a long-term care resident's realistic trajectory.

SELF-ASSESSMENT QUESTIONS

1. Is a documented functional assessment actually performed, specifically oriented to maintenance and decline-prevention rather than assuming a return-to-baseline recovery trajectory? — *A long-term care resident's realistic goal is often maintaining current function or slowing decline, not full recovery.*

Evidence: Functional assessment record

2. Is the plan genuinely individualized to that assessment, not a standard template applied regardless of the resident’s actual baseline? — *Verified by comparing several resident plans for genuine difference, not just name changes.*

Evidence: Comparative plan review

3. Is the plan reassessed on a defined schedule as the resident’s function changes over their stay? — *A plan set once may not reflect gradual change over a long-term stay.*

Evidence: Plan revision history

COMMON REASONS FOR A PARTIAL ANSWER

- **An assessment exists but uses an acute-recovery framework not adapted to LTC.**
- **Plans are set at admission and rarely revisited.**

IMPLEMENTATION PLAN

When	What
Week 1	Review whether current therapy framework fits LTC’s maintenance goals.
Week 2	Adopt or adapt a functional maintenance assessment tool.
Week 3	Review several current plans for genuine individualization.
Ongoing	Build in a defined reassessment schedule over the stay.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Comparative plan review	Compares plans across several residents for genuine individualization and maintenance-appropriate framing.

EVIDENCE BASE

World Health Organization. Integrated Care for Older People: Guidelines on Community-Level Interventions to Manage Declines in Intrinsic Capacity. Geneva: WHO; 2017.

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

10.2 Coordination Between Therapy and Daily Nursing Care

NON-NEGOTIABLE

Rehabilitation and restorative therapy goals are genuinely coordinated with daily nursing and care staff, so that functional gains made in therapy sessions are reinforced and carried through in everyday care, not undone by daily practices that work against the therapy plan.

In plain terms: What a resident works on in therapy actually carries through to how care staff treat them the rest of the day — not undone a few hours later by staff who don’t know the plan.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

A resident working on independent transfers during a therapy session, but lifted by daily care staff the rest of the day because they don’t know this is a goal, loses the functional gain the therapy session was meant to build — the limited therapy time is easily undone by hours of daily care working against it. This is specifically a long-term care risk, since residents spend far more hours with daily care staff than with the therapy team, making this coordination gap especially consequential here.

WHAT GOOD LOOKS LIKE

- Daily care staff genuinely know the resident's current therapy goals.
- A real shared communication mechanism connects therapy and daily care.
- Daily care staff can describe a specific

COMMON FAILURE MODES

- Therapy goals stay within the therapy department, not reaching daily care staff.
- Documentation is separate and disconnected, with no shared communication point.

resident's current therapy goal.

- Daily care staff can't describe therapy goals when asked directly.

WORKED EXAMPLE

IN PRACTICE

A resident working on independent standing transfers in physical therapy.

BEFORE	The resident practiced independent standing transfers with the physical therapist twice weekly, but daily care staff, unaware this was a specific goal, continued using a full lift for all transfers the rest of the week, undoing the practice gained in therapy.
ACTION	The facility built a visible, shared care plan flag — a simple bedside card noting current transfer ability and goal — with a brief weekly huddle between therapy and the relevant shift's daily care staff.
AFTER	The Monitor asked a daily care staff member about this resident's current therapy goal and received an accurate, specific answer. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether daily care staff currently know residents' specific therapy goals.
2. Build a simple, visible shared communication method — a bedside flag or care plan note.
3. Build a brief, recurring coordination point between therapy and daily care shifts.

The most common mistake: Therapy goals and progress stay documented within the therapy department's own records, with no simple, visible way for daily care staff to know and reinforce what the resident is working on the rest of the day.

SELF-ASSESSMENT QUESTIONS

1. Do daily care staff actually know the resident's current therapy goals, not just the therapy team working in isolation? — *A resident working on independent transfers in therapy, but lifted by staff the rest of the day, loses the functional gain.*

Evidence: Staff interview

2. Is there a genuine shared communication mechanism between therapy and daily care staff, not separate, unconnected documentation? — *A shared care plan or regular communication point, not isolated discipline-specific notes.*

Evidence: Shared communication record

3. Can daily care staff describe a specific resident's current therapy goal when asked? — *Evidence the coordination genuinely reaches frontline daily care, not just the therapy department.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A shared mechanism exists but isn't consistently used across all shifts.**
- **Daily staff know a goal exists generally but can't describe it specifically.**

IMPLEMENTATION PLAN

When	What
Week 1	Ask daily care staff about several residents' therapy goals to check awareness.
Week 2	Build a simple, visible shared communication method.
Week 3	Build a recurring coordination point between therapy and daily care.
Ongoing	Spot-check staff awareness of specific resident goals across shifts.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Daily care staff interview	Asks a daily care staff member to describe a specific resident's current therapy goal.

EVIDENCE BASE

World Health Organization. Integrated Care for Older People: Guidelines on Community-Level Interventions to Manage Declines in Intrinsic Capacity. Geneva: WHO; 2017.

10.3 Resident and Family Goal-Setting CORE

Rehabilitation and functional maintenance goals are set collaboratively with the resident and, where appropriate, family, in understandable terms, with realistic expectations genuinely communicated — not goals set unilaterally by the clinical team.

In plain terms: The resident, and family where appropriate, genuinely take part in setting therapy goals, with honest expectations about what’s realistic — not goals decided by staff alone.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

In a long-term care setting, honest communication that a goal is maintaining function rather than improving it matters specifically because the alternative — implying recovery is the target when it genuinely isn’t — sets up both resident and family for a disappointment that good communication could have avoided. Where cognitive impairment affects the resident’s own capacity to participate, genuine involvement of family or an authorized representative, rather than goal-setting that quietly bypasses real representation, is specifically important in this population.

WHAT GOOD LOOKS LIKE

- Goals are documented as genuinely collaborative, with visible resident input.
- Realistic expectations, including maintenance rather than improvement,

COMMON FAILURE MODES

- Goals are set by the clinical team with no documented resident input.
- Maintenance is framed optimistically as recovery

are honestly communicated.

- Where cognitive impairment exists, family or representative involvement is genuine and documented.

to avoid a difficult conversation.

- Goal-setting for a cognitively impaired resident bypasses genuine family involvement.

WORKED EXAMPLE

IN PRACTICE

A resident with moderate dementia and a recent fall-related mobility decline.

BEFORE

Therapy goals were set by the clinical team without a documented conversation with the resident's daughter, who held medical power of attorney. The goals were also framed in a way that implied the resident would likely regain her pre-fall mobility, which clinically wasn't a realistic expectation.

ACTION

The facility built a required goal-setting conversation with the authorized family representative for any cognitively impaired resident, with explicit, honest language distinguishing maintenance goals from recovery goals.

AFTER

The Monitor reviewed the documented conversation with the daughter and found honest, clear language about the maintenance-focused goal, with her understanding and agreement recorded. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a required goal-setting conversation involving the resident or authorized representative.
2. Train staff on honest, maintenance-versus-recovery language.
3. Document the conversation and the family's or resident's understanding.

The most common mistake: Framing a realistic maintenance goal in language that implies recovery, to avoid a difficult conversation with the resident or family, which sets up an expectation that clinical reality won't match.

SELF-ASSESSMENT QUESTIONS

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

Evidence: Goal-setting record

2. Are realistic expectations genuinely communicated, including where the goal is maintaining function rather than improving it? — *Honest, calibrated communication about what's realistic, not false reassurance of recovery.*

Evidence: Communication documentation

3. Where the resident has cognitive impairment, is family or an authorized representative genuinely involved in goal-setting? — *A real, documented involvement process, not goal-setting that bypasses the resident's actual representation.*

Evidence: Family involvement record

COMMON REASONS FOR A PARTIAL ANSWER

- **Family is informed of goals but not genuinely consulted in setting them.**
- **Maintenance goals are sometimes framed optimistically rather than honestly.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a required goal-setting conversation template.
Week 2	Train staff on honest maintenance-versus-recovery communication.
Week 3	Pilot with current residents and families.
Ongoing	Spot-check documented understanding for cognitively impaired residents.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Goal-setting record review	Checks for documented family or representative involvement and honest maintenance-versus-recovery language.

EVIDENCE BASE

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

10.4

Function Tracked with Validated Tools,
Decline Flagged Early

CORE

Functional status is tracked using a validated measurement tool at defined intervals, with any meaningful decline flagged and triggering a genuine care plan review, not relying on informal impression that may miss a gradual decline over time.

In plain terms: Function is tracked with a real measurement tool at set intervals, and any genuine decline actually triggers a care plan review — not just noticed informally and left unaddressed.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

A gradual functional decline, occurring over weeks or months of a long-term stay, is considerably harder to detect through informal impression than through a validated tool measured at consistent intervals — staff seeing a resident daily may not notice slow change the way a periodic objective measurement would. A decline that's noted informally but doesn't trigger an actual care plan review provides no real protective value; the entire purpose of tracking is defeated if detection doesn't connect to a genuine response.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- | | |
|---|--|
| <ul style="list-style-type: none"> • A validated, recognized functional tool is actually used, not an informal note. • The tool is applied at defined, consistent intervals appropriate to a long stay. • A flagged decline actually triggers a documented care plan review. | <ul style="list-style-type: none"> • Function is tracked only through informal staff impression, not a validated tool. • Measurement happens irregularly rather than on a fixed schedule. • A noted decline doesn't actually trigger a documented care plan review. |
|---|--|

WORKED EXAMPLE

IN PRACTICE

A resident experiencing a gradual mobility decline over several months.

BEFORE	Function was tracked informally through staff observation notes. A gradual decline in mobility over four months went largely unaddressed since no single staff member saw the full trajectory, each shift only noticing the resident “seemed about the same” compared to recent days.
ACTION	The facility adopted a validated functional measurement tool applied monthly for all residents, with any score drop beyond a defined threshold automatically flagging a care plan review.
AFTER	The Monitor reviewed a subsequent case where a monthly measurement caught a meaningful decline that informal observation had missed, triggering a documented care plan review and therapy adjustment. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Select a validated functional tool appropriate to the resident population.
2. Set a fixed measurement interval appropriate to a long-term stay.

3. Build an automatic trigger connecting a flagged decline to a care plan review.

The most common mistake: Relying on informal staff observation to detect functional decline, which is considerably less reliable for catching a gradual change over weeks or months than a validated tool measured at consistent intervals.

SELF-ASSESSMENT QUESTIONS

1. Is a validated, recognized functional measurement tool actually used, not an informal, ad hoc note? — *A validated tool provides a consistent, comparable measure; informal notes often miss a gradual decline.*

Evidence: Functional measurement record

2. Is the tool applied at defined, consistent intervals appropriate to a long-term stay? — *Irregular measurement makes genuine trend detection over a long stay difficult.*

Evidence: Measurement schedule

3. Does a flagged decline actually trigger a documented care plan review, not just get noted without follow-through? — *A decline identified but not actioned provides no real protective value.*

Evidence: Decline-to-review traceability

COMMON REASONS FOR A PARTIAL ANSWER

- **A tool is used but a flagged decline doesn't reliably trigger review.**
- **Measurement intervals are inconsistent across residents.**

IMPLEMENTATION PLAN

When	What
Week 1	Select a validated functional tool appropriate to the population.
Week 2	Set and communicate a fixed measurement interval.
Week 3	Build an automatic decline-to-review trigger.
Ongoing	Trace flagged declines to confirm review actually occurs.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Decline-to-review traceability review	Traces a specific flagged functional decline to a resulting documented care plan review.

EVIDENCE BASE

World Health Organization. Integrated Care for Older People: Guidelines on Community-Level Interventions to Manage Declines in Intrinsic Capacity. Geneva: WHO; 2017.

10.5

Equipment and Assistive Device Provision
Matches Need

CORE

Assistive devices and equipment — mobility aids, orthotics, adaptive equipment, positioning supports — are assessed, fitted, and provided to match the resident’s actual and evolving functional need, with staff trained in correct use, not a one-time provision never revisited.

In plain terms: Equipment is genuinely matched to what the resident currently needs, care staff are shown how to use it correctly, and it’s reassessed as needs change over a long stay — not fitted once and forgotten.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

A fitting made at admission reflects the resident’s function at that single point in time — over a long-term stay spanning months or years, that same equipment may no longer genuinely fit an evolved need, whether due to gradual decline or, in some cases, improvement. Equipment used incorrectly by daily care staff unfamiliar with its correct application, not just the therapy team who originally fitted it, is a specific and common safety risk in a setting where daily care staff handle the equipment far more often than therapists do.

- Equipment provision is based on a documented individual assessment.
- Daily care staff, not just the therapy team, are trained in correct use.
- Equipment is reassessed as the resident's needs evolve over their stay.

- Equipment is provided from what's available rather than a genuine fit assessment.
- Only the therapy team is trained in correct use; daily care staff are not.
- Equipment fitted at admission is never reassessed over a long stay.

WORKED EXAMPLE

IN PRACTICE

A resident fitted with a specific wheelchair at admission eighteen months earlier.

BEFORE

The wheelchair fitted at admission had never been reassessed, despite the resident's posture and positioning needs having changed significantly over eighteen months, risking discomfort and skin integrity issues from a now poorly fitting seat.

ACTION

The facility built a scheduled equipment reassessment at a defined interval for all residents with assistive devices, alongside a correct-use training requirement extended specifically to daily care staff, not only the therapy team.

AFTER

The Monitor reviewed the resident's record and found a scheduled reassessment had identified and corrected a positioning issue, with daily care staff confirmed as trained in correct use of the adjusted equipment. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check how long it's been since current residents' equipment was last reassessed.
2. Build a scheduled reassessment interval.

3. Extend correct-use training specifically to daily care staff, not just therapy.

The most common mistake: Treating an equipment fitting made at admission as permanent, without a scheduled reassessment over what can be a years-long stay during which the resident's functional needs genuinely evolve.

SELF-ASSESSMENT QUESTIONS

1. Is equipment provision based on a documented individual assessment, not a default or convenience-driven choice? — *Whatever's readily available, rather than what genuinely fits the resident's need, is a specific, checkable gap.*
Evidence: Equipment assessment record
2. Are daily care staff trained in correct use of the resident's specific equipment, not just the therapy team? — *Equipment used incorrectly by staff unfamiliar with it can be unsafe or ineffective.*
Evidence: Staff training record
3. Is equipment reassessed as the resident's needs evolve over their stay, not fitted once and never revisited? — *A fitting assessed once at admission may no longer be appropriate months or years into a long-term stay.*
Evidence: Reassessment schedule and record

COMMON REASONS FOR A PARTIAL ANSWER

- Only the therapy team, not daily care staff, is trained in correct equipment use.
- No scheduled reassessment interval exists for equipment already provided.

IMPLEMENTATION PLAN

When	What
Week 1	Audit equipment reassessment history for current residents.
Week 2	Build a scheduled reassessment interval.
Week 3	Extend correct-use training to daily care staff.
Ongoing	Spot-check daily care staff confidence with equipment use.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Equipment reassessment review	Checks equipment reassessment history against the defined interval and confirms daily care staff training.

EVIDENCE BASE

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

10.6

Restraint-Free and Least-Restrictive Mobility Support

STANDARD

Mobility and functional support is provided through the least restrictive means appropriate to the resident’s safety, with genuine effort to avoid restraint or over-restriction as a substitute for adequate staffing or supervision — not restriction used as a convenience measure.

In plain terms: Residents get the least restrictive support that keeps them safe — restriction is never used simply because it’s more convenient than adequate supervision or staffing.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

Restriction used as a first response, rather than as a genuine last resort after real alternatives are tried, is a well-documented risk pattern in long-term care settings, often emerging from inadequate staffing or supervision rather than genuine clinical necessity. A blanket restriction policy applied to all residents sharing a certain condition, rather than individual clinical assessment, overlooks that restriction needs matter differently for each resident and can persist well past the point where it’s genuinely still necessary if never reviewed.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- A documented, genuine effort to use least-restrictive alternatives comes before any restriction.
- Any restriction carries a specific individual clinical justification, not a blanket policy.
- Restriction use is reviewed on a defined schedule.
- Restriction is applied as a first response rather than a genuine last resort.
- A blanket policy restricts all residents with a certain condition regardless of individual need.
- A restriction applied once is never reviewed for continued necessity.

WORKED EXAMPLE

IN PRACTICE

A facility reviewing its use of bed rails for fall-risk residents.

BEFORE	A blanket policy applied full bed rails to any resident flagged as fall-risk, regardless of individual assessment, with no documentation of alternatives tried or a schedule for reviewing whether the restriction remained necessary.
ACTION	The facility replaced the blanket policy with an individual fall-risk assessment process, documenting specific alternatives tried — low beds, bed alarms, increased supervision — before any restriction, with a monthly review of every active restriction's continued necessity.
AFTER	The Monitor reviewed a sample of residents and found individual justifications documented, with several previously restricted residents having had the restriction removed following a documented review. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether any blanket restriction policy exists, applied regardless of individual need.
2. Build a documented alternatives-first process before any restriction decision.

3. Build a scheduled review for every active restriction.

The most common mistake: A blanket restriction policy applied to all residents sharing a certain condition or risk flag, rather than genuine individual clinical assessment with documented alternatives tried first and a schedule for ongoing review.

SELF-ASSESSMENT QUESTIONS

1. Is there a documented, genuine effort to use the least restrictive approach before any restriction is applied? — *Restriction used as a first response, rather than a last resort after genuine alternatives are tried, is a specific, checkable risk.*

Evidence: Alternatives-tried documentation

2. Is any restriction documented with a specific, individual clinical justification, not a blanket facility policy applied regardless of the resident? — *A blanket approach applied to all residents of a certain condition, rather than individual assessment, is a specific failure mode.*

Evidence: Individual restriction justification

3. Is restriction use reviewed on a defined schedule to check whether it remains genuinely necessary? — *A restriction applied once and never reviewed can persist long after it's genuinely needed.*

Evidence: Restriction review schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **Individual assessment exists but alternatives tried aren't well documented.**
- **A review schedule exists but isn't consistently followed.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit current restriction use for blanket-policy patterns.
Week 2	Build an individual assessment and alternatives-first process.
Week 3	Build a scheduled review for every active restriction.
Ongoing	Track restriction review completion against the schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Restriction record review	Checks a sample of active restrictions for individual justification, alternatives documentation, and review history.

EVIDENCE BASE

World Health Organization. Integrated Care for Older People: Guidelines on Community-Level Interventions to Manage Declines in Intrinsic Capacity. Geneva: WHO; 2017.

- ← Long-Term Care Standards — all standards
- Self-assess against these criteria →
- ← Standard 9 — Health & Migration