

ASF STANDARDS · LONG-TERM CARE · STANDARD 11

Standard 11 — Sustainable Care

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

CRITERIA IN THIS STANDARD

- 11.1 — Environmental Impact Is Genuinely Assessed Across a 24-Hour Operation
- 11.2 — Clinical and Incontinence Waste Is Genuinely Segregated and Responsibly Disposed
- 11.3 — Procurement Genuinely Considers Environmental Impact
- 11.4 — Energy and Water Use Are Genuinely Monitored and Reduced Where Possible
- 11.5 — Residents, Families, and Staff Are Genuinely Engaged in Sustainability Practice
- 11.6 — The Facility Genuinely Plans for Climate-Related Risk to Resident Safety
- 11.7 — Sustainability Commitments Are Genuinely Reviewed, Not Static

11.1

Environmental Impact Is Genuinely Assessed Across a 24-Hour Operation

STANDARD

The facility genuinely assesses its environmental impact — energy, water, laundry, and food service consumption — reflecting the real, continuous nature of residential

operation, not a partial assessment that overlooks the facility's round-the-clock resource use.

In plain terms: The facility has actually looked at its real environmental footprint across everything it does around the clock — not a partial picture that misses laundry, food, and overnight resource use.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A long-term care facility operates fundamentally differently from a clinic or hospital in one crucial respect: it is a residence, running continuously, with laundry, food service, heating, and cooling needs that never pause. These functions are often the facility's largest resource consumers by far, yet an environmental assessment that focuses narrowly on clinical operations — mirroring a hospital's approach — can miss them entirely. A genuine assessment has to reflect what the facility actually is: a 24-hour home for its residents.

WHAT GOOD LOOKS LIKE

- The assessment genuinely reflects the full 24-hour operation, not a partial snapshot.
- Laundry and food service are genuinely included, not overlooked as outside scope.
- The assessment is genuinely revisited periodically.

COMMON FAILURE MODES

- An assessment covers only clinical areas, missing the facility's largest resource users.
- Laundry volume and energy use have never been actually examined.

WORKED EXAMPLE

IN PRACTICE

A 60-bed facility that had only ever reviewed clinical supply costs.

BEFORE

The facility's only "environmental review" had looked at medical supply packaging, never

	touching the on-site laundry operation running multiple loads daily or the kitchen's food waste volume.
ACTION	A genuine baseline was compiled covering laundry water and energy use, kitchen food waste, and overall utility consumption, revealing laundry as by far the facility's largest water consumer.
AFTER	The Monitor reviewed the comprehensive baseline, confirming it genuinely covered laundry and food service alongside clinical areas. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull utility, laundry, and food service data for the past 12 months.
2. Compile a baseline that genuinely reflects the facility's full, continuous operation.

The most common mistake: Treating environmental assessment as a clinical exercise, missing laundry and food service — the facility's actual largest resource consumers.

SELF-ASSESSMENT QUESTIONS

1. Has the facility genuinely assessed its environmental impact across its full 24-hour operation? — *A real, comprehensive assessment, not a partial snapshot.*
Evidence: Baseline assessment document
2. Does this genuinely include laundry and food service? — *Real coverage of the facility's actual largest resource users.*
Evidence: Laundry/food service data
3. Is the assessment genuinely revisited periodically? — *Real, periodic review.*
Evidence: Review schedule

- **Clinical areas are assessed but laundry and food service are overlooked.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Compile a comprehensive baseline covering laundry, food, and utilities.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Baseline review	Reviews the baseline for genuine, comprehensive coverage including laundry and food.

SUPERVISOR TIPS

- **Specifically ask whether laundry has ever been included in an assessment.**

EVIDENCE BASE

World Health Organization. WHO Guidance for Climate-Resilient and Environmentally Sustainable Health Care Facilities. Geneva: WHO; 2020.

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

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

11.2 **Clinical and Incontinence Waste Is Genuinely Segregated and Responsibly Disposed** STANDARD

Clinical, hazardous, and high-volume incontinence waste is genuinely segregated at the point of generation and disposed of through a responsible, verified pathway — not a waste stream mixed for convenience given the facility's continuous, high-volume generation.

In plain terms: Medical and incontinence waste is kept genuinely separate from regular trash, right from when it's generated, and goes somewhere genuinely

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A long-term care facility generates genuinely high, continuous volumes of incontinence and clinical waste compared to a clinic that sees patients episodically — and this real, daily volume makes correct segregation and disposal a sustained operational discipline, not an occasional task. Under staffing pressure during busy shift periods, segregation is often exactly the practice that quietly lapses first.

WHAT GOOD LOOKS LIKE

- Clinical and incontinence waste is genuinely segregated consistently, including under staffing pressure.
- The disposal pathway is genuinely verified.
- Care staff are genuinely trained with real, observable compliance.

COMMON FAILURE MODES

- Segregation lapses during busy shift changes or staffing shortages.

WORKED EXAMPLE

IN PRACTICE	
<i>A facility where segregation reliably lapsed during the busy morning care routine.</i>	
BEFORE	During the rushed morning personal care routine, staff frequently used whatever bin was closest, mixing incontinence waste with general waste.
ACTION	Dedicated, clearly marked bins were placed in every resident room, removing the need to travel to a shared bin during the busy morning routine.
AFTER	The Monitor observed correct segregation during an actual morning care routine, the busiest and highest-risk period. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Place dedicated segregation bins in every resident room, not shared corridor bins.

The most common mistake: Segregation bins placed too far from the point of actual care, making correct use genuinely inconvenient during busy periods.

SELF-ASSESSMENT QUESTIONS

1. Is clinical and incontinence waste genuinely segregated at every point of generation? — *Real, consistent segregation, not a practice that lapses under staffing pressure.*

Evidence: Direct observation during busy periods

2. Is the disposal pathway genuinely verified? — *A real, verified pathway.*

Evidence: Contractor verification record

3. Are care staff genuinely trained with real, observable compliance? — *Real, demonstrated practice during actual resident care routines.*

Evidence: Training record, observation

COMMON REASONS FOR A PARTIAL ANSWER

- Segregation holds up during quiet periods but lapses during the busiest shifts.

IMPLEMENTATION PLAN

When	What
Week 1	Place dedicated bins in every resident room.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Direct observation	Observes segregation during an actual busy care period, not a quiet moment.

SUPERVISOR TIPS

- Observe during the morning care routine specifically, the highest-risk period.

[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.

11.3

Procurement Genuinely Considers Environmental Impact

CORE

Procurement decisions genuinely factor in environmental impact alongside cost and resident need — including the facility’s recurring, high-volume purchases of continence products, bedding, and food supplies — not sustainability treated as an afterthought with purchasing decided purely on price.

In plain terms: When the facility buys its ongoing, large-volume supplies — continence products, bedding, food — it actually thinks about environmental impact as one real factor, not purely the cheapest option.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A long-term care facility’s highest-volume recurring purchases — continence products, bedding, catering supplies — carry a genuinely significant cumulative environmental footprint given the sheer, continuous volume consumed. This is marked Core because these are precisely the purchases where environmental consideration, applied consistently, has the greatest real impact; a facility can hold stated sustainability values while every actual high-volume purchasing decision ignores them entirely.

WHAT GOOD LOOKS LIKE

- Environmental impact is genuinely weighed for the

COMMON FAILURE MODES

- High-volume supplies are purchased purely on unit cost with no

- A real, documented instance shows environmental considerations genuinely influencing a purchase.
- Food service and catering are genuinely reviewed for waste reduction.

WORKED EXAMPLE

IN PRACTICE

A facility reviewing its continence product supply contract.

BEFORE	Continence product supply was renewed annually on price alone, with no consideration of packaging volume or supplier sustainability credentials.
ACTION	The next supply renewal included environmental factors in the evaluation criteria, and a lower-packaging-waste supplier was selected at a comparable price point.
AFTER	The Monitor reviewed the documented decision showing environmental considerations genuinely influencing the choice. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add environmental consideration to the evaluation criteria for the facility’s highest-volume supply contracts.

The most common mistake: High-volume, recurring purchases renewed on autopilot, with environmental impact never actually entering the evaluation.

SELF-ASSESSMENT QUESTIONS

1. Does procurement genuinely weigh environmental impact for the facility’s highest-volume purchases? — *Real, documented*

2. Is there a real, documented instance of a procurement choice genuinely influenced by environmental considerations? — A concrete, real example.

Evidence: Specific purchasing decision record

3. Are food service and catering choices genuinely reviewed for waste reduction opportunities? — A real, ongoing review given recurring daily volume.

Evidence: Food service review record

COMMON REASONS FOR A PARTIAL ANSWER

- **Environmental consideration happens for some supply categories but not the highest-volume ones.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Add environmental criteria to high-volume supply contract evaluations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Procurement record review	Reviews a high-volume purchasing decision for documented environmental consideration.

SUPERVISOR TIPS

- **Ask about the facility's largest-volume supply contract specifically.**

EVIDENCE BASE

NHS England. Delivering a Net Zero National Health Service. London: NHS England; 2022.

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

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

Energy and Water Use Are Genuinely

11.4 Monitored and Reduced Where Possible

STANDARD

The facility genuinely monitors its energy and water consumption, pursuing real, achievable reductions — balanced against the genuine, non-negotiable need to maintain resident comfort and safety temperatures around the clock, not efficiency pursued at the expense of resident wellbeing.

In plain terms: The facility actually tracks what it spends on energy and water, and takes real steps to use less where that’s genuinely possible — but never at the expense of keeping residents genuinely warm, cool, and comfortable.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Energy efficiency in a long-term care setting carries a genuine tension that doesn’t exist in most other facility types: older residents are often more vulnerable to temperature extremes, and a cost-driven efficiency measure that compromises genuine thermal comfort or safety is not a real improvement — it’s a real risk relocated. Genuine efficiency here means pursuing improvements that save resources without ever compromising resident safety or comfort, not efficiency pursued regardless of that cost.

WHAT GOOD LOOKS LIKE

- Consumption is genuinely tracked.
- Efficiency improvements genuinely preserve resident comfort and safety.
- Progress is genuinely reviewed periodically.

COMMON FAILURE MODES

- An efficiency measure compromises resident thermal comfort to save on costs.

IN PRACTICE

A facility considering a thermostat reduction for cost savings.

BEFORE

A proposal to lower winter thermostat settings by two degrees to cut heating costs had not been checked against actual resident comfort needs or clinical guidance on safe ambient temperatures for older residents.

ACTION

Instead, the facility pursued window insulation upgrades, achieving a genuine, comparable energy saving without any reduction in resident comfort temperature.

AFTER

The Monitor reviewed the energy data showing the genuine saving, with resident temperature settings unchanged. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Set up basic consumption tracking.
2. Pursue efficiency improvements that don't touch resident comfort temperatures first.

The most common mistake: Pursuing a cost-saving efficiency measure that compromises genuine resident thermal comfort or safety.

SELF-ASSESSMENT QUESTIONS

1. Is energy and water consumption genuinely tracked? — *Real, ongoing tracking.*

Evidence: Consumption tracking record

2. Has the facility genuinely pursued an improvement that does not compromise resident comfort? — *A real, concrete improvement balanced against genuine resident wellbeing.*

Evidence: Specific improvement record

3. Is progress genuinely reviewed periodically? — *Real, periodic review.*

COMMON REASONS FOR A PARTIAL ANSWER

- Tracking exists but efficiency measures have never actually been pursued.

IMPLEMENTATION PLAN

When	What
Week 1-2	Set up consumption tracking and identify a comfort-neutral improvement.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Tracking review	Reviews consumption data and confirms resident comfort was never compromised.

SUPERVISOR TIPS

- Specifically ask whether any efficiency measure ever affected resident temperature settings.

EVIDENCE BASE

International Finance Corporation. Greenhouse Gas Emissions Reduction in Healthcare Facilities. Washington DC: IFC; 2021.

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

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

Residents, Families, and Staff Are

11.5 Genuinely Engaged in Sustainability Practice

STANDARD

Staff genuinely understand and participate in the facility’s sustainability practices, and residents and families are genuinely made aware of relevant initiatives where appropriate — not a sustainability policy known only to management with no real engagement from the people who actually live there or care for them.

In plain terms, Staff actually know what the facility is doing to be more sustainable and genuinely take part — and residents and families know about it too, where that’s genuinely appropriate.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A long-term care facility is, genuinely, residents' home — which makes sustainability a shared, lived practice rather than a purely operational policy. Residents and families who are genuinely informed about relevant initiatives, where appropriate, often respond positively, and staff who genuinely understand and participate in sustainability practice are far more likely to sustain it in real, daily routines rather than it existing only as a management-level aspiration.

WHAT GOOD LOOKS LIKE

- Staff can genuinely describe a real sustainability practice.
- Residents and families are genuinely made aware where appropriate.
- Staff input is genuinely sought and considered.

COMMON FAILURE MODES

- Staff are unaware of any specific sustainability practice.

WORKED EXAMPLE

IN PRACTICE

A facility whose sustainability efforts were known only to the administrator.

BEFORE	A switch to a lower-waste continence product line had happened, but care staff were unaware of the change or its rationale.
ACTION	A brief team briefing explained the change, and a small newsletter note informed families, with positive feedback received.

The Monitor asked a care staff member who could describe the change and its reasoning. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Brief staff on current sustainability practices.

The most common mistake: Sustainability decisions known only at management level, never communicated to the staff and families who are genuinely part of daily facility life.

SELF-ASSESSMENT QUESTIONS

1. Can staff asked directly describe a genuine sustainability practice? — *Real, demonstrated staff awareness.*

Evidence: Staff interview

2. Are residents and families genuinely made aware of relevant initiatives where appropriate? — *Real, visible communication.*

Evidence: Family/resident communication

3. Is staff input genuinely sought and considered? — *Real, two-way engagement.*

Evidence: Staff suggestion record

COMMON REASONS FOR A PARTIAL ANSWER

- Day staff are aware but night staff have never been briefed.

IMPLEMENTATION PLAN

When	What
Week 1	Brief all shifts, including nights, on current practices.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a care staff member to describe a specific practice.

SUPERVISOR TIPS

- Ask a night-shift staff member, not just day staff.

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

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

11.6

The Facility Genuinely Plans for Climate-Related Risk to Resident Safety

CORE

The facility genuinely considers climate-related risks to the continuous safety of its residents — extreme heat, power outages affecting medical equipment and climate control, supply chain disruption — with a real, workable response, given that residents who cannot independently evacuate or self-regulate depend entirely on the facility’s preparedness.

In plain terms: The facility has actually thought through what happens to resident safety during a heatwave or power cut — a real plan, because residents here genuinely cannot just leave or manage on their own.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core because the stakes of climate-related disruption are genuinely different in a residential care setting than almost anywhere else: residents often cannot evacuate independently, cannot self-regulate body temperature as effectively as younger adults, and depend on the facility’s continuous climate control and power supply for basic safety, not just comfort. A power outage during a heatwave is not an inconvenience here — it is a direct, serious safety risk, and the facility’s preparedness is what stands between that risk and actual harm.

WHAT GOOD LOOKS LIKE

- Specific climate-related risks to resident safety are

COMMON FAILURE MODES

- No backup plan exists for climate control during a

- A real, workable response plan exists, including backup power for climate control.
- This plan is genuinely reviewed and tested across all shifts.

WORKED EXAMPLE

IN PRACTICE	
A facility with no backup plan for a summer power outage.	
BEFORE	A previous summer power outage had left the facility without air conditioning for several hours, handled reactively with staff using fans, with no formal plan or backup generator capacity for critical cooling.
ACTION	A backup generator sized to cover at least critical climate-control zones was installed, with a documented activation protocol and a tabletop exercise conducted with staff across all three shifts.
AFTER	The Monitor reviewed the generator specification and confirmed night-shift staff could describe the activation protocol. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Identify the facility’s most significant climate-related risk to resident safety.
2. Build a real response plan, including backup power for critical climate control.
3. Test the plan with staff across all shifts, not just daytime.

The most common mistake: A response plan that has only ever been walked through with day-shift staff, leaving night and weekend staff genuinely unprepared.

1. Has the facility genuinely identified its specific climate-related risks to resident safety? — *A real, specific risk identification.*

Evidence: Risk identification document

2. Is there a real, workable response plan, including backup power for climate control? — *A genuine, usable plan.*

Evidence: Response plan document

3. Is this plan genuinely reviewed and tested across all shifts? —

Real, periodic review and testing across the full 24-hour cycle.

Evidence: Testing record across shifts

COMMON REASONS FOR A PARTIAL ANSWER

- A plan exists but has never been tested with night-shift staff.

IMPLEMENTATION PLAN

When	What
Week 1-3	Build a response plan including backup power for critical climate control.
Week 4	Test the plan with staff across all shifts.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Night-shift interview	Asks a night-shift staff member to describe the emergency protocol.

SUPERVISOR TIPS

- Specifically ask a night-shift staff member, not just day staff.

EVIDENCE BASE

World Health Organization. Operational Framework for Building Climate Resilient Health Systems. Geneva: WHO; 2015.

[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.

11.7

Sustainability Commitments Are Genuinely Reviewed, Not Static

STANDARD

The facility’s sustainability goals and practices are genuinely reviewed and updated as circumstances change — not a document written once and never genuinely examined for whether it still reflects the facility’s actual practice.

In plain terms: The facility’s sustainability goals actually get revisited over time — not written once and left to go stale.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A document written once and filed away stops being a genuine reflection of the facility’s real commitments as suppliers, staff, and circumstances change over time. Genuine, periodic review is what keeps sustainability commitments actually meaningful rather than a symbolic statement disconnected from the facility’s real, current practice.

WHAT GOOD LOOKS LIKE

- Goals are genuinely reviewed on a real, defined schedule.
- A real, documented instance shows a goal genuinely being revised.
- Responsibility for review is genuinely assigned to a specific person.

COMMON FAILURE MODES

- A document was written once and never revisited.

WORKED EXAMPLE

IN PRACTICE

A facility whose sustainability statement predated several supplier changes.

BEFORE	A sustainability statement written two years earlier still referenced a laundry supplier the facility no longer used.
ACTION	The facility administrator was formally assigned annual review responsibility, and the first review updated the document to reflect current suppliers and practices.
AFTER	The Monitor reviewed the updated, dated document showing genuine, real revisions. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Assign named responsibility for annual review.

The most common mistake: A document nobody is specifically responsible for revisiting, so it simply never gets reviewed.

SELF-ASSESSMENT QUESTIONS

1. Are sustainability goals genuinely reviewed on a real schedule?

— *A real, periodic review.*

Evidence: Review schedule

2. Is there a real, documented instance of a goal genuinely being revised? — *A concrete, real example.*

Evidence: Revision history

3. Is responsibility genuinely assigned to a specific person? — *A real, named accountability.*

Evidence: Assigned responsibility documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **A schedule exists but hasn't actually been followed consistently.**

When	What
Week 1	Assign named review responsibility and conduct the first genuine review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Revision history review	Reviews the document’s revision history for genuine, dated updates.

SUPERVISOR TIPS

- Ask who is specifically responsible for the review.

EVIDENCE BASE

United Nations Environment Programme. Sustainable Healthcare Facilities Guidance. Nairobi: UNEP; 2022.

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

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

- ← LTC Standards — all standards
- Self-assess against these criteria →
- Standard 12 — Digital Care & AI →

ASF STANDARDS · LONG-TERM CARE · STANDARD 12

Standard 12 — Digital Care and Artificial Intelligence Systems for Care

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

CRITERIA IN THIS STANDARD

- 12.1 — Digital Systems Are Genuinely Evaluated Before Adoption
- 12.2 — Digital Care Never Disadvantages a Resident or Family Who Cannot Use It
- 12.3 — Genuine Technical Support Is Available for Digital Systems
- 12.4 — AI Systems Are Introduced in Line With Law and Best-Practice Guidance
- 12.5 — AI Systems Are Genuinely Monitored for Unintended Consequences
- 12.6 — Staff Are Genuinely Consulted Before an AI System Is Introduced
- 12.7 — Accountability for AI-Assisted Care Is Explicitly Defined
- 12.8 — Residents and Families Are Genuinely Informed When Care Involves AI

12.1

Digital Systems Are Genuinely
Evaluated Before Adoption

STANDARD

Before adopting any new digital system — care management software, family communication portal, fall-detection or monitoring technology — the facility genuinely evaluates its cost, benefit, and compatibility with existing systems, not adopted on vendor assurance with no real internal evaluation.

In plain terms: Before the facility adopts a new digital tool for resident care or family communication, someone has actually checked it’s worth it and will genuinely work — not adopted because a vendor made it sound good.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Long-term care facilities are increasingly offered fall-detection systems, family communication apps, and care management platforms, each promising real benefit but each requiring genuine evaluation before adoption — not assumption that a vendor’s claims translate directly into actual operational fit for this specific facility’s residents and routines.

WHAT GOOD LOOKS
LIKE

- A genuine cost/benefit evaluation happens before adoption.
- Compatibility with existing resident record systems is genuinely checked.
- Unintended consequences for resident care are genuinely considered.

COMMON FAILURE
MODES

- A system is adopted on a vendor demonstration with no independent evaluation.

IN PRACTICE

A facility considering a family communication app.

BEFORE

A vendor's free trial for a family update app was activated with no check of whether it would genuinely integrate with the facility's existing care documentation process.

ACTION

A brief evaluation during the trial confirmed genuine workflow fit and identified a real training need for less digitally confident staff before full rollout.

AFTER

The Monitor reviewed the evaluation notes and the resulting training plan. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a simple evaluation checklist before adopting any digital system.

The most common mistake: Treating a vendor trial as low-stakes and skipping evaluation entirely.

SELF-ASSESSMENT QUESTIONS

1. Is a genuine cost/benefit evaluation conducted before adoption?

— *A real, documented evaluation.*

Evidence: Evaluation checklist

2. Is compatibility with existing resident record systems genuinely checked? — *Real, verified compatibility.*

Evidence: Compatibility check record

3. Are unintended consequences for resident care genuinely considered? — *Real, proactive consideration.*

Evidence: Pre-launch risk review

COMMON REASONS FOR A PARTIAL ANSWER

- Evaluation happens for major systems but is skipped for smaller add-ons.

When	What
Week 1	Build an evaluation checklist.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Evaluation review	Reviews the evaluation record for a recently adopted digital system.

SUPERVISOR TIPS

- Ask about the most recently adopted digital tool.

EVIDENCE BASE

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

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

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

12.2

Digital Care Never Disadvantages a Resident or Family Who Cannot Use It

CORE

A genuine process ensures that residents and family members who cannot use digital devices, lack internet access, or are otherwise unable to engage digitally are never disadvantaged in care communication, family updates, or resident engagement — not digital convenience purchased at the cost of real connection for the residents and families least able to adapt.

In plain terms: A family member who can’t use the facility’s app still gets the same real updates about their loved one — a genuine alternative, not a quietly worse option.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

Family members of long-term care residents are often themselves older adults, and residents receiving care here, by definition, are an elderly or disabled population — making this criterion genuinely central rather than peripheral in this setting. This is marked Core because a family communication app that leaves a less digitally confident family member genuinely out of the loop about their loved one’s care isn’t a minor inconvenience — it’s a real, significant loss of connection to someone they love.

WHAT GOOD LOOKS LIKE

- A genuine, equally functional alternative exists for families and residents.
- New digital services are genuinely pre-tested with representative families.
- Real evidence shows the alternative delivers equivalent engagement.

COMMON FAILURE MODES

- Phone updates become deprioritised once an app is introduced.

WORKED EXAMPLE

IN PRACTICE	
A facility that introduced a family update app.	
BEFORE	After the app launched, staff began posting daily updates there exclusively, and families without the app or with limited comfort using it stopped receiving the same frequency of updates by phone.
ACTION	A policy was set requiring the same update frequency by phone for any family that preferred it, with staff time specifically allocated for these calls.
AFTER	The Monitor interviewed a family member using the phone option who confirmed receiving updates at the same frequency as app users. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Confirm non-digital families receive genuinely equivalent update frequency.

The most common mistake: A digital update channel quietly becoming the real primary channel, with the stated alternative receiving less frequent, lower-quality attention.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, equally functional alternative for families who cannot use digital channels? — *A real, equivalent alternative.*
Evidence: Documented alternative channel
2. Was a new digital service genuinely pre-tested with representative families? — *Real, prior testing.*
Evidence: Pre-launch testing record
3. Is there real evidence the alternative delivers equivalent engagement? — *A real, demonstrated instance.*
Evidence: Family interview or comparison data

COMMON REASONS FOR A PARTIAL ANSWER

- **The alternative exists but receives genuinely less frequent updates in practice.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit update frequency for non-app families against app users.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Family interview	Asks a non-digital family member about their actual update frequency.

SUPERVISOR TIPS

- **Ask a family member who doesn't use the app directly.**

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health. Geneva: WHO; 2021.

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

12.3

Genuine Technical Support Is Available for Digital Systems

STANDARD

The facility has genuine access to technical support — in-house, vendor-provided, or contracted — for its digital systems, with testing before full implementation, not systems left running with no real support behind them, which carries particular risk where fall-detection or monitoring technology is involved.

In plain terms: When a monitoring system breaks, there’s a real person to call — especially urgent here, since these systems can be directly tied to resident safety.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A fall-detection or monitoring system failing overnight, with no clear support path, is genuinely different in consequence from a booking system failing — a malfunctioning safety system could mean a resident fall goes undetected for longer than it should. Real, accessible support, especially covering overnight hours when the facility is least staffed, is what this criterion is actually protecting.

WHAT GOOD LOOKS LIKE

- Genuine, accessible support exists, including for safety-related systems.
- Testing genuinely occurs before implementation.
- A real, known escalation path covers night shifts.

COMMON FAILURE MODES

- Support exists only during business hours, with no overnight coverage.

IN PRACTICE

A facility with a monitoring system that failed overnight.

BEFORE

A fall-detection sensor malfunctioned at 2am with no night-shift knowledge of who to call, leaving it offline until the day administrator arrived.

ACTION

A 24-hour vendor support line was confirmed and posted at the night nursing station, with a documented fallback (increased manual rounding) for any monitoring outage.

AFTER

The Monitor asked a night-shift nurse who could correctly describe both the support line and the manual fallback protocol. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Confirm support coverage for safety-related systems genuinely extends to overnight hours.

The most common mistake: Support arrangements that only genuinely function during daytime business hours, leaving overnight gaps for safety-critical systems.

SELF-ASSESSMENT QUESTIONS

1. Does the facility have genuine, accessible support, including for safety-related systems? — *Real, available support with particular urgency for safety systems.*

Evidence: Support contract

2. Were genuine testing and quality checks performed before implementation? — *A real pre-launch check.*

Evidence: Testing record

3. Is there a real, known route to support overnight? — *A genuine, known path covering night and weekend shifts.*

Evidence: Night-shift staff interview

- **Support exists but night staff don’t actually know how to reach it.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm and post 24-hour support contacts for safety-related systems.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Night-shift interview	Asks a night-shift staff member about the support and fallback process.

SUPERVISOR TIPS

- **Ask specifically about overnight coverage, not just daytime.**

EVIDENCE BASE

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

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

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

12.4

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

STANDARD

Any artificial intelligence tool used to support fall-risk prediction, behavioural monitoring, or care planning is introduced in accordance with applicable law, or where none exists, with available best-practice guidance such as WHO’s AI ethics and governance guidance — not adopted with no reference to any external standard of responsible use.

In plain terms: Before using an AI monitoring tool, the facility has actually checked what the law requires and how it handles resident consent — not made it up as it

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

AI-assisted monitoring in long-term care carries a genuine, specific sensitivity: it often involves continuous observation of residents who may lack full capacity to consent, making the governance basis and the facility’s approach to consent genuinely important considerations that a formal review is designed to surface.

WHAT GOOD LOOKS LIKE

- AI systems are genuinely introduced in line with applicable law.
- Where no law exists, introduction is genuinely informed by recognized guidance.
- The facility can identify the specific basis, including consent considerations.

COMMON FAILURE MODES

- Resident or family consent for monitoring was never explicitly addressed.

WORKED EXAMPLE

IN PRACTICE	
A facility using an AI-assisted fall-risk monitoring system.	
BEFORE	The system had been installed with no formal consideration of resident consent or any check of applicable regulation around continuous monitoring.
ACTION	A governance review confirmed applicable regulation and formally documented the facility’s consent process, involving family or legal representatives where residents lacked capacity.
AFTER	The Monitor reviewed the governance note and the consent documentation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Document the governance basis and consent approach for any AI monitoring tool.

The most common mistake: Installing AI monitoring technology with no formal consideration of resident consent.

SELF-ASSESSMENT QUESTIONS

1. Is any AI system genuinely introduced in line with applicable law?
— *Real, verified compliance.*
Evidence: Regulatory check record

2. Where no law exists, is introduction genuinely informed by recognized guidance? — *A real, referenced source.*
Evidence: Documented guidance reference

3. Can the facility identify the specific governance basis, including consent? — *A real, specific answer covering resident consent.*
Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A guidance source is named but consent handling was never explicitly documented.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Document governance basis and consent process for AI monitoring.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Governance note review	Reviews the documented governance and consent basis.

SUPERVISOR TIPS

- **Ask specifically how resident consent was handled.**

EVIDENCE BASE

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

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

12.5 AI Systems Are Genuinely Monitored for Unintended Consequences

STANDARD

The facility genuinely monitors any AI-assisted fall-risk or behavioural tool for false alarms, missed events, and other unintended consequences — not deploying a tool and assuming it works as intended with no real, ongoing scrutiny, given the genuine risk of alarm fatigue undermining its actual protective purpose.

In plain terms: The facility actually keeps checking whether its monitoring tools are working as expected — and specifically watches for staff becoming numb to constant false alarms, which can undermine the whole point of the system.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Fall-detection and behavioural monitoring systems carry a genuinely specific failure mode: a high rate of false alarms can lead staff to develop real alarm fatigue, responding more slowly or dismissively over time — which means a system intended to improve resident safety can, if unmonitored, actually degrade it. Genuine monitoring has to watch for this specific pattern, not just raw accuracy.

WHAT GOOD LOOKS LIKE

- AI output is genuinely, periodically audited.
- Alarm fatigue among staff is genuinely monitored as a real risk.
- A documented instance exists of monitoring

COMMON FAILURE MODES

- A high false-alarm rate is never actually tracked or addressed.

WORKED EXAMPLE

IN PRACTICE

A facility with a fall-detection system generating frequent false alarms.

BEFORE

The system's false-alarm rate had never been tracked, and staff had begun responding more slowly to alerts, a pattern nobody had formally noticed.

ACTION

A monthly review of alert accuracy was introduced, revealing a genuinely high false-alarm rate, which was reported to the vendor for sensitivity recalibration.

AFTER

The Monitor reviewed the monthly review record and the vendor's subsequent recalibration. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Establish a monthly review of alert accuracy specifically tracking false-alarm rate.

The most common mistake: Treating any monitoring technology as inherently effective, never checking whether a high false-alarm rate is quietly undermining staff responsiveness.

SELF-ASSESSMENT QUESTIONS

1. Is AI-assisted output genuinely audited for false alarms or missed events? — *Real, ongoing audit.*

Evidence: Audit record

2. Is alarm fatigue among staff genuinely monitored? — *A real, specific concern genuinely tracked.*

Evidence: Staff response time data

3. Is there a documented instance of monitoring identifying a genuine issue? — *A real, concrete example.*

COMMON REASONS FOR A PARTIAL ANSWER

- Accuracy is reviewed but alarm fatigue specifically isn’t tracked.

IMPLEMENTATION PLAN

When	What
Week 1-2	Establish a monthly alert-accuracy and fatigue review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Audit review	Reviews the monitoring record for genuine, specific alarm-fatigue tracking.

SUPERVISOR TIPS

- Ask staff directly whether they ever feel numb to the alerts.

EVIDENCE BASE

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

ASF training courses on GMJ Academy →

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

12.6

Staff Are Genuinely Consulted Before an AI System Is Introduced

STANDARD

Direct care staff who will actually respond to an AI tool’s alerts are genuinely consulted before its introduction, with real training needs identified and addressed — not a tool rolled out to care staff with no engagement beyond a brief notification.

In plain terms: Before a new monitoring tool goes live, the care staff who will actually respond to its alerts have had a real say — including those on night shifts.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Care staff across all three shifts actually respond to monitoring alerts, and their genuine, practical input — especially from night staff, who are often most affected by a new alert system and most easily overlooked in daytime-scheduled consultations — is what identifies real workflow issues before they become patient safety concerns.

WHAT GOOD LOOKS LIKE

- Staff across all shifts are genuinely consulted.
- Consultation genuinely identifies training needs.
- Night staff specifically can describe genuine consultation.

COMMON FAILURE MODES

- Consultation happens only with day-shift staff.

WORKED EXAMPLE

IN PRACTICE

A facility introducing a new fall-detection system.

BEFORE	A consultation session was held during daytime hours only, meaning night staff — who would be the primary responders to overnight alerts — never had input.
ACTION	A separate consultation session was scheduled specifically for night-shift staff, surfacing a practical concern about alert audibility that was addressed before go-live.
AFTER	The Monitor interviewed a night-shift staff member who described the consultation and the resulting change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: Consultation scheduled only during daytime hours, systematically excluding the staff most affected by overnight monitoring technology.

SELF-ASSESSMENT QUESTIONS

1. Are staff across all shifts genuinely consulted before introduction?

— *Real, prior consultation reaching night staff.*

Evidence: Consultation record

2. Does consultation genuinely identify training needs? — *Real*

needs matched by real training.

Evidence: Training delivery record

3. Can night staff specifically describe having been genuinely

consulted? — *Tests whether consultation actually reached night staff.*

Evidence: Night-shift staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Day staff were consulted but night staff were not.**

IMPLEMENTATION PLAN

When	What
Before any launch	Hold consultation sessions reaching every shift.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Night-shift interview	Asks night-shift staff whether they felt genuinely consulted.

SUPERVISOR TIPS

- **Ask a night-shift worker specifically, not just day staff.**

EVIDENCE BASE

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

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

12.7 Accountability for AI-Assisted Care Is Explicitly Defined

CORE

The facility has genuinely considered and documented accountability for care decisions made with AI support — who is responsible when a fall-risk prediction or behavioural alert is wrong or missed — not leaving this as an unexamined question until an actual resident is harmed.

In plain terms: Everyone knows, in advance, who is actually responsible if a monitoring alert fails or a prediction is wrong — not a question nobody has thought through.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core because of a genuine, specific risk in this setting: staff can begin to over-rely on monitoring technology, implicitly treating it as a substitute for direct observation rather than a support to it.

Explicit accountability — making clear that the technology assists but does not replace actual care staff vigilance — protects against exactly this drift, which otherwise emerges gradually and invisibly.

WHAT GOOD LOOKS LIKE

- Clinical accountability is explicitly documented.
- Staff genuinely understand monitoring technology does not replace direct observation.
- A defined process exists for reviewing accountability after a missed-alert incident.

COMMON FAILURE MODES

- Staff gradually come to rely on the monitoring system as a substitute for rounds.

IN PRACTICE

A facility where staff had reduced manual rounding after installing fall-detection sensors.

BEFORE

Staff had informally reduced the frequency of manual room checks since the sensors were installed, effectively treating the technology as a substitute for direct observation.

ACTION

A clear policy was reissued: sensors support but never replace scheduled manual rounds, with accountability for resident safety explicitly remaining with care staff regardless of sensor status.

AFTER

The Monitor interviewed a care worker who could clearly state that rounding frequency had not changed and that accountability remained with staff. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Explicitly document that monitoring technology supports but never replaces direct observation.

The most common mistake: Staff gradually, informally reducing direct observation once monitoring technology is introduced, without this drift ever being explicitly addressed.

SELF-ASSESSMENT QUESTIONS

1. Is clinical accountability for an AI-supported decision explicitly documented? — *A real, clear answer.*

Evidence: Documented accountability policy

2. Do care staff genuinely understand monitoring does not replace direct observation? — *Real, demonstrated understanding.*

Evidence: Staff interview

3. Is there a defined process for reviewing accountability after a missed-alert incident? — *A real, usable process.*

COMMON REASONS FOR A PARTIAL ANSWER

- A policy exists but rounding frequency has quietly declined in practice anyway.

IMPLEMENTATION PLAN

When	What
Week 1	Reissue and reinforce the direct-observation policy.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a care worker to describe rounding frequency and accountability.

SUPERVISOR TIPS

- Check rounding frequency records against the stated policy.

EVIDENCE BASE

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

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

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

12.8

Residents and Families Are Genuinely Informed When Care Involves AI

STANDARD

A resident (or their family, where the resident cannot meaningfully participate) whose care involves an aspect delivered with AI system support is genuinely informed of this — not left to assume every decision was made by a human staff member alone, with disclosure treated as optional rather than a genuine, standard part of informed care.

In plain terms: If AI is actually involved in part of a resident’s care — a fall-detection sensor, for instance — the resident or their family genuinely knows this, not left to assume everything is purely human-monitored.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A resident’s or family’s genuine right to understand care includes knowing, in plain terms, when a monitoring or care decision involved an AI system rather than staff judgement alone. This is especially relevant in long-term care, where AI-assisted monitoring (fall detection, for instance) often runs continuously in the background — easy for a resident or family to never genuinely realise is there at all unless actively disclosed.

WHAT GOOD LOOKS LIKE

- Residents and families are genuinely informed when AI is involved in care.
- Disclosure is genuinely understandable, in plain language.
- A resident or family member can genuinely confirm they were told.

COMMON FAILURE MODES

- AI-assisted monitoring runs in the background with no genuine disclosure ever made to the resident or family.

WORKED EXAMPLE

IN PRACTICE

A facility using an AI-assisted fall-detection sensor.

BEFORE

The sensor’s role was mentioned only in a lengthy general admission document, which families signed without genuine awareness that an AI tool was actually monitoring their relative.

ACTION	A brief, plain-language conversation at admission now explains: “A sensor helps alert staff to a possible fall; a staff member always checks before responding.”
AFTER	The Monitor interviewed a family member who could genuinely confirm they understood AI was involved. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a brief, plain-language disclosure point at admission for any AI-assisted monitoring in use.

The most common mistake: AI-assisted monitoring that runs continuously with no genuine disclosure ever actually reaching the resident or family.

SELF-ASSESSMENT QUESTIONS

1. Are residents and families genuinely informed when AI is involved in care? — *Real, standard disclosure.*
Evidence: Disclosure protocol
2. Is this disclosure genuinely understandable, not buried in technical language? — *A real, plain-language explanation.*
Evidence: Admission materials
3. Can a family member asked directly confirm they were genuinely told? — *A real, concrete confirmation.*
Evidence: Family interview

COMMON REASONS FOR A PARTIAL ANSWER

- Disclosure exists in admission paperwork but families genuinely cannot recall or explain it when asked directly.

IMPLEMENTATION PLAN

When	What
Week 1-2	Draft plain-language disclosure wording for admission conversations and train staff to deliver it.

Method	What	Detail
ASK	Family interview	Asks a family member whether they were genuinely told AI was involved in their relative's care.

SUPERVISOR TIPS

- Ask a family member directly rather than relying on the admission form's existence alone.

EVIDENCE BASE

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

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

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

- ← LTC Standards — all standards
- Self-assess against these criteria →
- ← Standard 11 — Sustainable Care
- Standard 13 — Supporting the Care Workforce →

ASF STANDARDS · LONG-TERM CARE · STANDARD 13

Standard 13 — Supporting the Care Workforce

8 criteria · 3 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA

Principle 8, 6th Edition

CRITERIA IN THIS STANDARD

13.1 — Every Member of the Workforce Is Genuinely Credentialed for Their Actual Role

13.2 — Ongoing Competency Is Genuinely, Regularly Evaluated

13.3 — Staff Have Genuine Access to Ongoing Education and Skill Development

13.4 — Workforce Health and Safety Is Genuinely Protected, Including Manual Handling

13.5 — Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved

13.6 — Staff Are Genuinely Protected From Resident and Family Aggression

13.7 — Workforce Feedback Is Genuinely Gathered and Acted On

13.8 — Sick Leave and Attrition Data Genuinely Inform Organisational Learning

13.9 — Equality, Diversity and Inclusion Across the Workforce Are Genuinely Monitored

Every Member of the Workforce Is

13.1 Genuinely Credentialed for Their Actual Role

CORE

Every member of the facility’s workforce — employed carers, nurses, contracted agency staff covering shifts, and volunteers alike — has genuine assurance of the qualifications and scope of practice their role requires — not credentialing confined to directly-employed staff while agency shift-cover goes unchecked.

In plain terms: Everyone who actually cares for residents here — employed, agency, or volunteer — has had their real qualifications genuinely checked.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Long-term care facilities commonly rely on agency staff to cover shift gaps, and residents cannot distinguish between a permanent staff member and an agency worker — care quality and safety genuinely depend on every single person delivering care being properly credentialed, regardless of their employment relationship with the facility.

WHAT GOOD LOOKS LIKE

- Genuine credential assurance extends to agency staff.
- Scope of practice is genuinely verified.
- A real corrective process exists for a scope mismatch.

COMMON FAILURE MODES

- Agency staff credentials are assumed verified by the agency, never independently checked.

WORKED EXAMPLE

IN PRACTICE

A facility relying on agency staff for weekend shift coverage.

BEFORE	Agency staff were assumed vetted by their agency, with no independent facility-level verification of their actual qualifications before their first shift.
ACTION	A direct credential-verification step was added to the agency booking process, confirmed before any new agency worker's first shift at the facility.
AFTER	The Monitor reviewed verification records for recent agency placements. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add direct credential verification to your agency staff booking process.

The most common mistake: Trusting an agency's own vetting claims without independent verification by the facility itself.

SELF-ASSESSMENT QUESTIONS

1. Does genuine credential assurance extend to agency staff covering shifts? — *Real, consistent coverage.*

Evidence: Credential verification records

2. Is each person's scope of practice genuinely verified? — *A specific, documented match.*

Evidence: Scope verification record

3. Is there a real process if someone practises outside their verified scope? — *A genuine corrective process.*

Evidence: Correction procedure

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens for regular agency workers but not one-off emergency cover.**

When	What
Week 1	Add verification step to agency booking process.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Credential review	Reviews verification records for agency and employed staff alike.

SUPERVISOR TIPS

- Ask about the most recently placed agency worker specifically.

EVIDENCE BASE

The Joint Commission. Credentialing and Privileging Standards for Long-Term Care. Oakbrook Terrace: TJC; 2023.

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

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

13.2

Ongoing Competency Is Genuinely,
Regularly Evaluated

CORE

The continued competency of every workforce member — including specific competency in dementia care, safe manual handling, and medication administration appropriate to a residential setting — is genuinely, regularly evaluated, not assumed to remain current indefinitely once initial credentialing is complete.

In plain terms: Staff competency keeps getting genuinely checked — specifically including dementia care and safe manual handling, both genuinely central to this work.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

Dementia care and manual handling techniques evolve over time, and competency in these specific areas can genuinely degrade without regular refresh — a carer's manual handling technique from initial training years ago may not reflect current best practice, creating real risk to both residents and the carer themselves. This is marked Core because the consequences of an outdated technique are directly physical and serious for both parties.

WHAT GOOD LOOKS LIKE

- Ongoing competency is genuinely evaluated, including dementia care and manual handling specifically.
- Evaluation genuinely covers actual current duties.
- A genuine gap triggers a real response.

COMMON FAILURE MODES

- Manual handling technique is assumed correct from initial training, never reassessed.

WORKED EXAMPLE

IN PRACTICE	
<i>A facility where manual handling competency had not been reassessed since hire.</i>	
BEFORE	Manual handling technique was checked once at hiring, with some staff having worked over five years with no reassessment.
ACTION	An annual, hands-on manual handling competency check was introduced, directly observing actual technique during real resident transfers.
AFTER	The Monitor reviewed the annual check records, confirming genuine, direct observation rather than a self-report form. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: Manual handling competency checked by self-report form rather than real, direct observation.

SELF-ASSESSMENT QUESTIONS

1. Is ongoing competency genuinely evaluated, including dementia care and manual handling? — *A real, periodic evaluation.*

Evidence: Evaluation records

2. Does evaluation genuinely cover actual current duties? — *A specific, role-relevant check.*

Evidence: Role-specific criteria

3. Does a genuine gap trigger a real response? — *A genuine corrective process.*

Evidence: Correction record

COMMON REASONS FOR A PARTIAL ANSWER

- **Evaluation relies on self-report rather than direct observation.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce annual, direct-observation competency checks.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Evaluation review	Reviews evaluation for genuine, direct-observation substance.

SUPERVISOR TIPS

- **Ask to see an evaluation involving actual observed technique, not a form.**

EVIDENCE BASE

Institute of Medicine. Health Professions Education: A Bridge to Quality. Washington DC: National Academies Press; 2003.

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

13.3 Staff Have Genuine Access to Ongoing Education and Skill Development STANDARD

Every workforce member has genuine access to ongoing education — including dementia care, palliative care, and safe manual handling refreshers — not education treated as a one-time induction event with nothing meaningful offered afterward.

In plain terms: Staff can actually keep learning after they're hired — particularly dementia and palliative care, genuinely central to this setting's complexity.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Dementia care and palliative care are genuinely complex, evolving clinical domains, and staff without ongoing education in them risk relying on outdated or incomplete approaches to some of the most sensitive, high-stakes aspects of resident care — comforting a distressed resident with dementia, or supporting a dying resident and their family.

WHAT GOOD LOOKS LIKE

- Genuine, ongoing access to education beyond induction.
- Real development opportunities in dementia and palliative care specifically.
- Staff can describe a real opportunity taken.

COMMON FAILURE MODES

- Education stops after initial induction, with no dementia or palliative care refresher offered.

IN PRACTICE

A facility with no ongoing dementia care education since initial induction.

BEFORE

Staff had received dementia care training only during their initial onboarding, with nothing offered since, despite evolving best practice.

ACTION

A biannual dementia care refresher was introduced, along with access to an external palliative care course for staff interested.

AFTER

The Monitor interviewed staff who could describe the refresher training taken. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a biannual dementia care refresher at minimum.

The most common mistake: Treating initial dementia or palliative care training as sufficient for the duration of someone's employment.

SELF-ASSESSMENT QUESTIONS

1. Does every workforce member have genuine, ongoing access to education? — *Real, continuing access.*

Evidence: Education policy

2. Are genuine development opportunities offered in dementia and palliative care? — *Real opportunities relevant to this setting.*

Evidence: Training calendar

3. Can staff describe a real opportunity taken in the past year? — *A real, specific example.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Compliance training exists but genuine skill-building opportunities are rare.**

When	What
Week 1-2	Schedule biannual dementia and palliative care refreshers.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks staff to describe recent dementia or palliative care education taken.

SUPERVISOR TIPS

- Ask specifically about dementia or palliative care training, not generic compliance.

EVIDENCE BASE

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

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

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

13.4 Workforce Health and Safety Is Genuinely Protected, Including Manual Handling CORE

The facility genuinely protects the health and safety of its workforce — required vaccinations, personal protective equipment, and specifically real, effective prevention of manual handling injuries from resident transfers, which represent a genuinely elevated occupational risk in this setting — not staff safety treated as secondary to resident care.

In plain terms: The people caring for residents are genuinely kept safe — with specific, real attention to manual handling injuries, which happen a lot in this kind of work.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Manual handling injuries are genuinely one of the most common occupational injuries in long-term care, arising from repeated resident transfers, repositioning, and mobility assistance throughout every shift. This is marked Core because the cumulative physical toll on care staff is real, serious, and directly tied to how consistently proper equipment and technique are actually used — not whether a policy document exists describing them.

WHAT GOOD LOOKS LIKE

- Real manual handling equipment is available and actually used.
- PPE is genuinely available and used.
- Vaccinations are genuinely tracked.

COMMON FAILURE MODES

- Hoists exist but staff skip them under time pressure, manually lifting instead.

WORKED EXAMPLE

IN PRACTICE

A facility with hoists that staff frequently bypassed.

BEFORE	Hoists were available but staff often skipped them for quicker manual transfers during busy periods, resulting in a rising rate of staff back injuries.
ACTION	Additional hoists were purchased to reduce wait time for equipment access, and a refresher training specifically addressed the time-pressure temptation to skip proper technique.
AFTER	The Monitor observed hoist use during an actual transfer and confirmed consistent, correct technique. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: Equipment present but genuinely bypassed under time pressure, with no one actually checking real, observed use.

SELF-ASSESSMENT QUESTIONS

1. Are genuine, specific manual handling measures in place and actually used? — *Real, observed use.*

Evidence: Direct observation during transfers

2. Is PPE genuinely available and used? — *Real, observed use.*

Evidence: Direct observation

3. Are vaccinations genuinely tracked? — *Real, verified tracking, particularly important given resident vulnerability.*

Evidence: Vaccination records

COMMON REASONS FOR A PARTIAL ANSWER

- **Equipment is available but genuinely underused during busy shifts.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit equipment access and actual use during transfers.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Direct observation	Observes an actual resident transfer for correct equipment use.

SUPERVISOR TIPS

- **Observe a real transfer during a busy period, not a quiet moment.**

EVIDENCE BASE

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

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

13.5

Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved

STANDARD

A genuine process exists for investigating and resolving workplace issues raised by staff — including whistleblowing concerns about resident care quality — with real protection from adverse treatment, not a grievance process that exists on paper with no real follow-through.

In plain terms: When staff raise a concern — including about resident care quality — it actually gets looked into, and they’re genuinely protected.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Long-term care staff are often the first to notice declining resident care quality — understaffing, neglect, poor practice — and whistleblower protection here carries genuinely higher stakes, since residents themselves may lack the capacity or voice to raise these concerns independently. Staff who don’t trust the reporting channel will often stay silent precisely when their observations matter most.

WHAT GOOD LOOKS LIKE

- A genuine, accessible process exists.
- Real evidence of genuine resolution.
- Genuine protection from adverse treatment.

COMMON FAILURE MODES

- Concerns about care quality go unreported due to fear of retaliation.

WORKED EXAMPLE

IN PRACTICE

A facility where staff were reluctant to report understaffing-related care gaps.

BEFORE

Staff had informally mentioned concerns about understaffing affecting resident care but had not formally reported it, fearing it would be seen as complaining.

ACTION

An anonymous reporting option was added, and the first report led to a genuine staffing review and schedule adjustment.

AFTER

The Monitor reviewed the report and the resulting staffing adjustment. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce an anonymous reporting option for care-quality concerns.

The most common mistake: Staff concerns about care quality discussed informally but never formally raised, for fear of being seen as complaining.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, accessible process for raising issues, including care-quality concerns? — *A real, known process.*

Evidence: Process documentation

2. Is there real evidence of genuine resolution? — *Genuine follow-through.*

Evidence: Resolution log

3. Are staff genuinely protected from adverse treatment? — *Real, demonstrated protection.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- A process exists but staff don't genuinely trust it for care-quality concerns specifically.

When	What
Week 1-2	Introduce or strengthen anonymous reporting option.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks staff whether they'd feel safe raising a care-quality concern.

SUPERVISOR TIPS

- Ask specifically about care-quality concerns, not just general workplace issues.

EVIDENCE BASE

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

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

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

13.6 Staff Are Genuinely Protected From Resident and Family Aggression

STANDARD

The facility takes genuine, concrete steps to protect staff from aggression — including behavioural aggression linked to dementia or cognitive impairment, which requires a genuinely different, trauma-informed response than aggression from a cognitively intact individual — not workplace aggression treated as an unavoidable feature of residential care.

In plain terms: Real, specific steps protect staff from aggression — including specific training for dementia-related behaviour, which needs a genuinely different, compassionate response.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Aggression from a resident with dementia is genuinely different in nature and appropriate response from aggression by a cognitively intact individual — it's typically not intentional, and the correct response is trauma-informed de-escalation rather than a standard security protocol. Staff untrained in this distinction may respond in ways that escalate the situation or, conversely, may absorb real harm without recognizing it as something the facility should formally address and support them through.

WHAT GOOD LOOKS LIKE

- Genuine, specific training covers dementia-related aggression distinctly.
- Incidents are genuinely tracked.
- Staff can describe a real instance where a measure worked.

COMMON FAILURE MODES

- Generic de-escalation training is used with no dementia-specific component.

WORKED EXAMPLE

IN PRACTICE	
<i>A facility using generic de-escalation training with no dementia-specific component.</i>	
BEFORE	Staff had received only generic workplace violence training, with no specific guidance on responding to dementia-related behavioural aggression, which is a genuinely common and different situation.
ACTION	Dementia-specific, trauma-informed de-escalation training was delivered, alongside the existing incident log being updated to distinguish dementia-related incidents.
AFTER	The Monitor confirmed dementia-specific training had been delivered and reviewed the updated

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Deliver dementia-specific, trauma-informed de-escalation training.

The most common mistake: Treating all workplace aggression identically, without recognizing dementia-related behavioural aggression needs a genuinely different, trauma-informed response.

SELF-ASSESSMENT QUESTIONS

1. Does genuine, specific training cover dementia-related aggression distinctly? — *Real, specific measures appropriate to this setting's distinct risk profile.*

Evidence: Training records

2. Are incidents genuinely tracked and reviewed? — *Real, systematic tracking.*

Evidence: Incident log

3. Can staff describe a real instance where a measure genuinely worked? — *A real, concrete example.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- Training is generic rather than genuinely dementia-specific.

IMPLEMENTATION PLAN

When	What
Week 1-2	Deliver dementia-specific de-escalation training.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Training record review	Reviews training for genuine, dementia-specific content.

SUPERVISOR TIPS

- Ask staff specifically about dementia-related behavioural training.

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

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

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

13.7

Workforce Feedback Is Genuinely Gathered and Acted On

STANDARD

The facility has a genuine, systematic approach to gathering staff feedback across all shifts — including night staff, whose voice is often overlooked — with real analysis and a genuine, implemented response, not feedback collected occasionally with no real pattern of actual improvement.

In plain terms: Staff across every shift, including nights, get genuinely asked how working here actually is, and real changes happen as a result.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Feedback processes scheduled during daytime hours systematically exclude night-shift staff, who make up a genuine, significant portion of a 24-hour facility’s workforce and often have genuinely distinct concerns — staffing ratios, safety during quiet hours, isolation — that day-focused surveys may never capture.

WHAT GOOD LOOKS LIKE

- Feedback is genuinely gathered across all shifts.
- Feedback is genuinely analysed.
- A documented instance shows a genuine,

COMMON FAILURE MODES

- Surveys and meetings happen only during day shift.

WORKED EXAMPLE

IN PRACTICE

A facility whose staff survey had a near-zero response rate from night staff.

BEFORE

An annual survey was distributed during day-shift handover meetings, meaning night staff almost never saw or completed it.

ACTION

The survey was made available digitally with a genuine deadline spanning all shifts, and a brief in-person session was held specifically during a night handover.

AFTER

The Monitor reviewed the survey response data showing genuine participation from night staff. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check current feedback response rates by shift to identify any night-staff gap.

The most common mistake: Feedback processes scheduled exclusively during day shift, systematically excluding night-staff voice.

SELF-ASSESSMENT QUESTIONS

1. Is feedback genuinely gathered across all shifts, including nights?

— *Real, ongoing collection reaching night staff.*

Evidence: Survey response data by shift

2. Is feedback genuinely analysed? — *A real, documented analysis.*

Evidence: Analysis notes

3. Is there a documented instance of feedback genuinely leading to a change? — *A real, concrete example.*

Evidence: Change record

- **Feedback is gathered but night-staff response rate remains genuinely low.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Redesign feedback collection to genuinely reach all shifts.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Response rate review	Reviews survey response data broken down by shift.

SUPERVISOR TIPS

- **Specifically check the response rate from night-shift staff.**

EVIDENCE BASE

NHS England. NHS Staff Survey National Results. Leeds: NHS England; 2023.

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

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

Sick Leave and Attrition Data
13.8 Genuinely Inform Organisational Learning

STANDARD

The facility genuinely monitors staff sick leave and the real reasons people leave — a sector with genuinely elevated attrition risk from physical and emotional demand — using this to inform genuine changes supporting workforce wellbeing and retention, not attrition treated as an unexamined, unavoidable cost of doing business.

In plain terms: The facility actually looks at why staff get sick or leave — genuinely common in this physically and emotionally demanding field — and uses what it learns to make things better.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Long-term care is genuinely one of the sectors with the highest documented workforce attrition, driven by a real combination of physical strain, emotional demand, and often lower relative compensation compared to other healthcare settings. A facility that treats this attrition as an unavoidable, unexamined feature of the sector misses the real, actionable patterns — burnout drivers, scheduling issues, specific unit-level problems — that genuine investigation can actually surface and address.

WHAT GOOD LOOKS LIKE

- Sick leave data is genuinely monitored.
- Real reasons for leaving, including burnout, are actually captured.
- A documented instance shows this data genuinely informing a change.

COMMON FAILURE MODES

- High attrition is accepted as normal for the sector, with no real investigation.

WORKED EXAMPLE

IN PRACTICE

A facility with persistently high carer turnover accepted as “normal for the industry.”

BEFORE	Carer turnover was significantly above the facility's own target, but this was treated as an unavoidable industry feature with no real investigation into facility-specific causes.
ACTION	Structured exit interviews revealed a specific, addressable pattern: inconsistent shift scheduling was a recurring, genuine complaint, leading to a scheduling policy review.
AFTER	The Monitor reviewed exit interview data and the resulting scheduling policy change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce structured exit interviews rather than accepting attrition as unexamined.

The most common mistake: Accepting high attrition as a simple, unavoidable feature of the sector, rather than investigating genuinely addressable facility-specific causes.

SELF-ASSESSMENT QUESTIONS

1. Is sick leave data genuinely monitored? — *Real, ongoing analysis.*

Evidence: Sick leave records

2. Are real reasons for leaving, including burnout, actually captured?

— *Real, specific exit data.*

Evidence: Exit interview records

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

Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- **Exit interviews happen but results are never analysed for genuine patterns.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce structured exit interviews and genuine pattern analysis.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Exit data review	Reviews exit interview records and any resulting change.

SUPERVISOR TIPS

- **Ask whether attrition has ever been genuinely investigated, not just accepted.**

EVIDENCE BASE

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

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

Equality, Diversity and Inclusion

13.9 Across the Workforce Are Genuinely Monitored

STANDARD

The organisation genuinely monitors and responds to real patterns of equity across recruitment, work allocation, scheduling, and promotion — including across night and day shifts — not an assumption that fair treatment exists simply because no formal complaint has been raised.

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

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Inequity in recruitment, scheduling, or promotion can genuinely persist for years without a single formal complaint — people often don't report a pattern they can't fully see themselves, or don't trust reporting to change anything. In a round-the-clock residential setting, this genuinely extends to scheduling across night and day shifts, where a pattern can be even easier to overlook. Genuine, proactive monitoring of real workforce data is what actually surfaces a pattern that individual complaints alone would likely never reveal.

WHAT GOOD LOOKS LIKE

- Workforce data is genuinely monitored for patterns.
- A genuine pattern triggers a real response.

COMMON FAILURE MODES

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

WORKED EXAMPLE

IN PRACTICE

A facility that had never reviewed its own night-shift scheduling for patterns.

BEFORE

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

ACTION

A quarterly scheduling equity review was introduced, which identified and corrected a genuine, unintentional pattern.

AFTER

The Monitor reviewed the review documentation and the resulting correction. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a regular review of recruitment, scheduling, and promotion data, including across all shifts.

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

SELF-ASSESSMENT QUESTIONS

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

A real, documented monitoring process.

Evidence: Monitoring protocol

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

Evidence: Response record

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

COMMON REASONS FOR A PARTIAL ANSWER

- **Data exists but has genuinely never been reviewed specifically for equity patterns, particularly across night shifts.**

IMPLEMENTATION PLAN

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

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **Ask to see the actual data behind the last equity review, including night-shift staff specifically.**

EVIDENCE BASE

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

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

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

← **LTC Standards — all standards**

Self-assess against these criteria →

← **Standard 12 — Digital Care & AI**