

Medical Transport Standards — Full Guidance

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 38 criteria.

8 standards · 38 criteria · Version 1.0

ASF STANDARDS · MEDICAL TRANSPORT · STANDARD 1

Standard 1 — Vehicle & Equipment Readiness

4 criteria · 3 non-negotiable · 1 core · Version 1.0

CRITERIA IN THIS STANDARD

- 1.1 — Vehicle Maintenance Current and Documented
- 1.2 — Medical Equipment Checked and Calibrated
- 1.3 — Medication Storage Meets Requirements
- 1.4 — Vehicle Safety Equipment Present and Functional

1.1 Vehicle Maintenance Current and Documented

NON-NEGOTIABLE

Every transport vehicle has a current, documented maintenance record meeting or exceeding manufacturer and national roadworthiness requirements, with no vehicle used for patient transport past its maintenance due date.

In plain terms: Every vehicle on the road carrying a patient is genuinely road-safe and properly serviced, verified — not assumed because it looks fine.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

A vehicle breakdown during a critical patient transport is not merely an operational inconvenience — it directly delays or endangers the clinical care the transport exists to provide. Maintenance gaps are rarely dramatic; they are a service interval that slips by a few weeks because the vehicle “seemed fine,” compounding quietly until a failure occurs at the worst possible moment.

WHAT GOOD LOOKS LIKE

- A maintenance log exists for every vehicle, current against its required interval.
- No vehicle past its maintenance due date is in active patient transport use.
- Pre-shift vehicle checks are performed and logged by the crew, every shift.

COMMON FAILURE MODES

- A service interval slips because the vehicle “seemed fine” to drive.
- A vehicle known to be overdue is still assigned because no backup is available.
- Pre-shift checks are a checklist that exists but isn’t consistently completed.

WORKED EXAMPLE

IN PRACTICE

A small inter-facility transport operator with a three-vehicle fleet.

BEFORE	One vehicle’s service interval passed by eleven days. It was still assigned to transports because the other two vehicles were already committed and the vehicle “drove fine” on a quick test around the lot.
ACTION	The operator built a hard rule: any vehicle reaching its maintenance due date is immediately flagged out of service in the scheduling system, which physically prevents it from being assigned, with a standing arrangement for a rental backup vehicle during tight periods.
AFTER	The Monitor cross-checked the maintenance log against the vehicle assignment log for the past six months and found no instance of an overdue

vehicle being assigned to a transport. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check every vehicle's current maintenance status right now.
2. Build a hard system-level block preventing overdue vehicle assignment.
3. Arrange a backup vehicle option for when your own fleet is tight.

The most common mistake: Assigning a vehicle that's slightly overdue for service because it "seems fine" and no backup is readily available, rather than treating the due date as a genuine hard stop.

SELF-ASSESSMENT QUESTIONS

1. Does a maintenance log exist for every vehicle, with the most recent service within its required interval? — *Not a schedule that exists on paper but is routinely missed.*

Evidence: Vehicle maintenance log

2. Is any vehicle past its maintenance due date still in active patient transport use? — *A single such instance is a direct patient-safety failure.*

Evidence: Maintenance log cross-checked against assignment log

3. Are pre-shift vehicle checks performed and logged by the crew before each transport? — *A scheduled maintenance program does not replace a real pre-shift check.*

Evidence: Pre-shift check log

COMMON REASONS FOR A PARTIAL ANSWER

- An overdue vehicle is kept in service because no backup exists.
- Pre-shift checks exist as a form but aren't consistently completed.

IMPLEMENTATION PLAN

When	What
Week 1	Audit current maintenance status for every vehicle in the fleet.

When	What
Week 2	Build a scheduling-system block for overdue vehicles.
Week 3	Arrange a backup vehicle contingency.
Ongoing	Review pre-shift check completion periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Maintenance-assignment cross-check	Compares maintenance due dates against actual vehicle assignment records for any overdue use.

EVIDENCE BASE

National Fire Protection Association. NFPA 1917: Standard for Automotive Ambulances. Quincy (MA): NFPA; 2024.

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

1.2 Medical Equipment Checked and Calibrated

NON-NEGOTIABLE

Medical equipment carried on board — monitors, defibrillators, ventilators, oxygen delivery — is checked before each shift, calibrated per manufacturer schedule, and any malfunctioning equipment is immediately removed from service.

In plain terms: Every piece of medical equipment on board actually works, checked that day — not assumed because it worked last week.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Equipment failure during transport is uniquely dangerous because, unlike a hospital ward, there is no immediate backup device or engineering support available mid-route. A defibrillator discovered non-functional only when actually needed, during an emergency, represents a failure that a routine pre-shift check exists specifically to prevent.

WHAT GOOD LOOKS LIKE

- A documented pre-shift check is actually completed, verifiable through logs.
- Calibration is current and verifiable by certificate for every piece requiring it.
- Malfunctioning equipment has a documented, followed immediate-removal procedure.

COMMON FAILURE MODES

- A pre-shift checklist exists as a form but isn't consistently filled in.
- Calibration is assumed current because the equipment appears to function.
- A malfunction is noted but the equipment stays on board "just in case."

WORKED EXAMPLE

IN PRACTICE

A crew discovering a defibrillator issue during a pre-shift check.

BEFORE

Pre-shift checks were technically required but frequently skipped during busy mornings, with crew assuming equipment that worked the previous shift would still be functional.

ACTION

The organization made the pre-shift check a hard gate in the dispatch system — a shift cannot be marked ready for assignment until the check is logged complete — removing the option to skip it under time pressure.

AFTER

During a subsequent pre-shift check, a crew member caught a defibrillator battery issue before the vehicle was assigned, swapped the unit, and logged the catch. The Monitor reviewed this record as evidence the check genuinely functions. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether pre-shift checks are actually completed, not just available as a form.
2. Build a hard gate preventing shift assignment without a logged check.
3. Confirm calibration certificates are current for all equipment requiring it.

The most common mistake: Treating the pre-shift check as optional under time pressure, assuming equipment that worked the previous shift will still be functional.

SELF-ASSESSMENT QUESTIONS

1. Is a documented pre-shift equipment check actually completed, not just available as a checklist nobody fills in? — *Verified against actual completed logs, not the existence of a checklist template.*

Evidence: Pre-shift check log

2. Is calibration current on every piece of equipment requiring it, verifiable by certificate or log? — *Not assumed current because the equipment appears to be functioning.*

Evidence: Calibration certificates

3. Where equipment malfunctions mid-shift, is there a documented, followed procedure for removing it from service immediately? — *A malfunction discovered but not immediately actioned risks being used on the next patient.*

Evidence: Equipment removal record

COMMON REASONS FOR A PARTIAL ANSWER

- **Pre-shift checks exist but are skipped under time pressure.**
- **A malfunction is noted verbally but no formal removal record exists.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit pre-shift check completion rates.
Week 2	Build a hard gate requiring the check before shift assignment.
Week 3	Confirm calibration status for all equipment.
Ongoing	Review removal records for any malfunction trend by equipment type.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Pre-shift log and calibration review	Checks pre-shift log completion rates and calibration certificate currency.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

1.3 Medication Storage Meets Requirements

NON-NEGOTIABLE

Medications carried on board are stored at required temperature, secured against unauthorized access, checked for expiry on a fixed schedule, and controlled substances are logged with chain-of-custody discipline.
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In plain terms: Medications on board are stored correctly, checked regularly, and controlled substances are tracked with a real, gapless log — not an honor-system count.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

A vehicle's temperature environment is far less controlled than a hospital pharmacy, making medication storage genuinely harder to maintain correctly during transport operations. Controlled substance chain-of-custody matters particularly in a mobile setting, where the usual fixed-location security of a hospital pharmacy doesn't apply, and gaps in the log are both a diversion risk and a genuine accountability gap.

WHAT GOOD LOOKS LIKE

- Storage temperature is actually monitored, not assumed from the cooling unit's presence.
- No expired medications are found on checks.
- Controlled substances are logged with genuine chain of custody and witness signature.

COMMON FAILURE MODES

- A cooling unit exists but temperature is never actually verified.
- Expiry checks are infrequent enough that expired stock is occasionally found.
- Controlled substance counts rely on an honor-system log with gaps.

WORKED EXAMPLE

IN PRACTICE

A transport organization reviewing controlled substance tracking.

BEFORE	Controlled substances were counted at the start and end of each shift by the single crew member on duty, with no independent witness, leaving the log vulnerable to undetected discrepancy.
ACTION	The organization required a two-person count with both signatures at shift start and end, and introduced a continuous temperature logger for the medication storage unit with a defined excursion response.
AFTER	The Monitor reviewed the controlled substance log and found consistent two-signature entries with no gaps over the past quarter. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether controlled substance counts have independent witness signatures.
2. Verify medication storage temperature is actually monitored, not assumed.
3. Check current stock for any expired medication right now.

The most common mistake: A single crew member counting and logging controlled substances alone, with no independent witness, which leaves no real safeguard against an undetected discrepancy.

SELF-ASSESSMENT QUESTIONS

1. Is medication storage temperature actually monitored, not just assumed from the storage unit's general function? — *A cooling unit with no verification is an assumption, not a control.*

Evidence: Temperature log

2. Are expired medications found during checks, suggesting the expiry-check schedule isn't functioning? — *Any expired medication found on board indicates a gap in the check process.*

Evidence: Expiry check log

3. Are controlled substances logged with a genuine chain of custody, not an honor-system count? — *A controlled substance log with gaps or no witness signature is a real, checkable risk.*

Evidence: Controlled substance log with witness signatures

COMMON REASONS FOR A PARTIAL ANSWER

- **Controlled substance counts lack an independent witness.**
- **Temperature monitoring exists but has gaps during longer shifts.**

IMPLEMENTATION PLAN

When	What
Week 1	Audit current medication storage and controlled substance logging practice.
Week 2	Build a two-person witnessed count requirement.
Week 3	Install or verify continuous temperature monitoring.

When	What
Ongoing	Review the controlled substance log periodically for gaps.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Controlled substance log review	Reviews the log for witnessed, gapless entries and checks temperature monitoring records.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

1.4

Vehicle Safety Equipment Present and Functional

CORE

Every vehicle carries functional safety equipment appropriate to its operating environment — fire extinguisher, first aid kit beyond patient care supplies, hazard triangles, communication backup — checked on the same schedule as medical equipment.

In plain terms: Basic vehicle safety gear is actually present and works — checked regularly, not just assumed to be there.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Vehicle safety equipment tends to receive less routine attention than medical equipment, precisely because it's rarely needed — which means gaps can persist unnoticed for a long time. A fire extinguisher discovered empty is of no use at the exact moment it matters most, and this category of equipment check is easy to deprioritize against the more visibly urgent medical equipment checks.

WHAT GOOD LOOKS LIKE

- Safety equipment is checked on the same fixed schedule as medical equipment.
- Communication backup exists for known coverage gaps on regular routes.
- Checks are verified independently, not solely by crew self-report.

COMMON FAILURE MODES

- Safety equipment checks are deprioritized against medical equipment checks.
- No communication backup exists for a known coverage gap on a regular route.
- Checks rely entirely on crew self-report with no independent spot-check.

WORKED EXAMPLE

IN PRACTICE

A transport organization auditing its pre-shift check thoroughness.

BEFORE	Pre-shift checks focused heavily on medical equipment, with safety equipment like the fire extinguisher and hazard triangles checked only informally and infrequently, since they were rarely, if ever, actually needed.
ACTION	The organization integrated safety equipment into the same formal pre-shift checklist used for medical equipment, with the same hard gate requiring completion before shift assignment.
AFTER	The Monitor reviewed recent pre-shift logs and found safety equipment checks consistently completed alongside medical equipment checks. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether safety equipment is on the same formal check schedule as medical equipment.
2. Identify any known communication coverage gaps on regular routes.

3. Integrate safety equipment checks into the existing pre-shift gate.

The most common mistake: Treating safety equipment checks as less urgent than medical equipment checks, since safety equipment is rarely actually needed, which is exactly why gaps go unnoticed the longest.

SELF-ASSESSMENT QUESTIONS

1. Is safety equipment checked on a fixed schedule, not only noticed missing when needed? — *A fire extinguisher discovered empty during an actual emergency is a specific, serious failure.*

Evidence: Safety equipment check log

2. Does communication backup exist for areas with known cellular or radio coverage gaps on regular routes? — *Relevant specifically for inter-city or rural transport routes.*

Evidence: Route coverage assessment, backup communication plan

3. Is safety equipment checked by someone other than solely relying on crew self-report? — *Independent verification catches what a rushed self-check might miss.*

Evidence: Independent spot-check record

COMMON REASONS FOR A PARTIAL ANSWER

- **Safety equipment checks are less rigorous than medical equipment checks.**
- **No communication backup plan exists for known coverage gaps.**

IMPLEMENTATION PLAN

When	What
Week 1	Integrate safety equipment into the formal pre-shift checklist.
Week 2	Map known communication coverage gaps on regular routes.
Week 3	Arrange backup communication for identified gap areas.
Ongoing	Conduct periodic independent spot-checks of safety equipment.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Vehicle inspection	Physically inspects safety equipment presence and function on a selected vehicle.

EVIDENCE BASE

National Fire Protection Association. NFPA 1917: Standard for Automotive Ambulances. Quincy (MA): NFPA; 2024.

← Medical Transport Standards — all standards

Standard 2 — Crew Qualification & Competence
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ASF STANDARDS · MEDICAL TRANSPORT · STANDARD 2

Standard 2 — Crew Qualification & Competence

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

CRITERIA IN THIS STANDARD

- 2.1 — Crew Scope of Practice Matches Transport Acuity
 - 2.2 — Certification Current, Not Lapsed
 - 2.3 — Driver Training Specific to Patient Transport
 - 2.4 — Fatigue Management for Long-Distance Transport
 - 2.5 — Minimum Crew Complement Per Transport Type
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2.1 Crew Scope of Practice Matches Transport Acuity

NON-NEGOTIABLE

Every transport is staffed with crew whose certified scope of practice matches or exceeds the clinical acuity of the patient being transported, verified before departure, not assumed from general crew availability.

In plain terms: The crew assigned to a transport can actually, legally and clinically handle whatever that specific patient might need — checked before leaving, not assumed from who happened to be on shift.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Assigning crew based on availability rather than acuity match is a specific, well-documented risk pattern in patient transport — a basic-level crew assigned to a critical transport simply because they were the ones on shift leaves the patient without the clinical capability the transport genuinely requires. The verification step before departure exists precisely to catch this mismatch before the vehicle leaves, when correction is still straightforward.

WHAT GOOD LOOKS LIKE

- Acuity is formally assessed before crew assignment, not left to informal judgment.
- A documented instance exists of a transport being delayed or reassigned for acuity mismatch.
- Crew certification is verifiable as current on request, for any crew member.

COMMON FAILURE MODES

- Crew assignment is based on who's available, not a formal acuity match.
- No example exists of the matching requirement holding under scheduling pressure.
- Certification status requires digging through files rather than quick verification.

WORKED EXAMPLE

IN PRACTICE

A dispatch center managing a critical inter-city transport request.

BEFORE

A critical-acuity transport request came in while only a basic-level crew was immediately available. The dispatcher assigned them anyway, reasoning the transport “should be fine” and that waiting for an appropriate crew would cause an unacceptable delay.

ACTION

The organization built a formal acuity assessment step into the dispatch workflow, with a hard rule preventing assignment confirmation until a

matching crew is identified, paired with a mutual-aid agreement with a neighboring service for coverage gaps.

AFTER

The Monitor reviewed a recent instance where a transport was correctly delayed fifteen minutes to secure an appropriately qualified crew, with the delay and reasoning documented. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a formal acuity assessment step into your dispatch process.
2. Set a hard rule against assigning mismatched crew, even under time pressure.
3. Arrange mutual aid or backup coverage for genuine acuity-mismatch gaps.

The most common mistake: Assigning whichever crew is immediately available under the reasoning that the transport “should be fine,” rather than treating the acuity-match requirement as a genuine hard rule.

SELF-ASSESSMENT QUESTIONS

- 1.** Is patient acuity formally assessed before crew assignment, not left to informal judgment? — *Without a formal assessment step, acuity-to-crew matching depends on individual judgment alone.*

Evidence: Acuity assessment record

- 2.** Is there a documented instance of a transport being delayed or reassigned because available crew didn’t match required acuity? —

Evidence the matching requirement holds even under scheduling pressure.

Evidence: Dispatch delay record

- 3.** Can crew scope-of-practice certification be verified as current for any crew member on request? — *Retrievable immediately, not reconstructed after the fact.*

Evidence: Certification record

COMMON REASONS FOR A PARTIAL ANSWER

- Acuity assessment happens informally rather than through a defined process.
- No backup arrangement exists for when matching crew isn't immediately available.

IMPLEMENTATION PLAN

When	What
Week 1	Build a formal acuity assessment step into dispatch.
Week 2	Set and communicate the hard no-mismatch assignment rule.
Week 3	Arrange mutual aid or backup coverage for gap situations.
Ongoing	Review dispatch records periodically for any mismatch instance.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Dispatch and certification record review	Checks acuity assessment records and certification currency against crew assignments.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

2.2 Certification Current, Not Lapsed

NON-NEGOTIABLE

Every crew member's clinical certification — paramedic, EMT, nursing, or equivalent — is current and verified before each shift, with no crew member working a transport shift on a lapsed certification. Clinical performance and competency are also formally evaluated on a defined schedule, distinct from certification currency alone.

In plain terms: Nobody works a shift on an expired certification — checked before every shift, not just when they were first hired.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

A certification check performed only at hiring captures a snapshot that quickly becomes outdated — certifications have renewal cycles, and without a genuine per-shift or regularly scheduled check, a lapse can go unnoticed for weeks or months while that crew member continues working. This is also a legal and insurance exposure for the organization, beyond the direct clinical risk.

WHAT GOOD LOOKS LIKE

- Certification status is checked before each shift, not only at hiring.
- No instance exists of a crew member working on a lapsed certification.
- A documented process immediately stands down a crew member upon lapse.

COMMON FAILURE MODES

- Certification is checked only at hiring, with no ongoing verification.
- A lapse goes unnoticed because staff are expected to self-report.
- No clear stand-down process exists once a lapse is identified.

WORKED EXAMPLE

IN PRACTICE	
<i>A paramedic whose recertification renewal date passed unnoticed.</i>	
BEFORE	Certification checks happened only at hiring. A paramedic's recertification lapsed by six weeks before anyone noticed, discovered only when an insurance audit flagged the gap retrospectively.
ACTION	The organization built an automated system tracking every certification's expiry date, flagging any crew member approaching lapse thirty days in advance, with a hard scheduling block

	preventing shift assignment once a certification actually lapses.
AFTER	The Monitor reviewed the certification tracking system and confirmed current status for all active crew, with no lapsed certifications found. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check current certification status for all crew right now.
2. Build a tracking system with advance expiry warnings, not reliance on self-report.
3. Build a hard scheduling block preventing assignment on a lapsed certification.

The most common mistake: Relying on staff to self-report their own certification renewal status, rather than building a system that proactively tracks and flags expiry dates.

SELF-ASSESSMENT QUESTIONS

1. Is certification status checked before each shift, not only at hiring?
— *Certifications expire; a check only at hiring misses renewal gaps entirely.*

Evidence: Certification tracking system

2. Is there any instance of a crew member working a shift with a lapsed certification? — *A single such instance is a direct, serious failure.*

Evidence: Certification audit

3. Is there a documented process for immediately standing down a crew member whose certification lapses? — *Not an informal expectation that staff will self-report.*

Evidence: Stand-down procedure

4. Is each crew member's clinical performance and competency formally evaluated on a defined schedule, documented and shared with them? — *A genuine, periodic, documented evaluation, distinct from certification status checking alone.*

Evidence: Performance evaluation record

COMMON REASONS FOR A PARTIAL ANSWER

- Tracking relies on staff self-report rather than a proactive system.
- No hard scheduling block prevents assignment on a lapsed certification.

IMPLEMENTATION PLAN

When	What
Week 1	Audit current certification status for all crew.
Week 2	Build a tracking system with advance expiry alerts.
Week 3	Build a hard scheduling block on lapsed certifications.
Ongoing	Review the tracking system monthly for upcoming expirations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Certification audit	Cross-checks current certification status for all active crew against scheduling records.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

2.3

Driver Training Specific to Patient Transport

CORE

Drivers complete training specific to emergency or patient transport driving — distinct from a standard driving license — covering safe emergency driving, patient-comfort driving technique, and route-specific hazards.

In plain terms: Drivers get real training specific to driving with a patient on board — not just a regular driving license and general experience.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Driving with a patient on board, sometimes under genuine emergency conditions, is a materially different skill from everyday driving, requiring awareness of patient-comfort technique and the specific risks of emergency driving that a standard license doesn't cover. An organization that treats a standard driving license as sufficient qualification is overlooking a real, well-documented training gap.

WHAT GOOD LOOKS LIKE

- Training goes genuinely beyond a standard license into transport-specific technique.
- Training is refreshed periodically, not completed once at hiring.
- Drivers are briefed on known hazards for regularly traveled routes.

COMMON FAILURE MODES

- A standard driving license is treated as sufficient qualification on its own.
- Training happened once at hiring with no refresher since.
- No route-specific hazard briefing exists for regularly traveled corridors.

WORKED EXAMPLE

IN PRACTICE

A transport organization reviewing its driver qualification requirements.

BEFORE

New drivers were hired based on a standard driving license and general experience, with no specific emergency or patient-transport driving training beyond a brief ride-along with a senior driver.

ACTION

The organization built a formal patient-transport driving course covering emergency driving technique and patient-comfort driving, required before independent assignment, with a biennial refresher and route-specific hazard briefings for regular corridors.

AFTER The Monitor reviewed training completion records for current drivers and found full coverage, including recent refreshers. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether current driver training goes beyond a standard license.
2. Build or source a specific patient-transport driving course.
3. Build route-specific hazard briefings for regular corridors.

The most common mistake: Treating a standard driving license plus general experience as adequate preparation, without specific training in the distinct demands of emergency or patient-transport driving.

SELF-ASSESSMENT QUESTIONS

1. Does driver training go beyond a standard license, covering patient-transport-specific technique? — *A standard driving license alone does not cover the specific demands of patient transport.*

Evidence: Training curriculum and completion record

2. Is training refreshed on a schedule, not completed once at hiring? — *Driving habits can drift without periodic reinforcement.*

Evidence: Refresher training schedule

3. Are drivers briefed on known hazards for regularly traveled routes? — *Route-specific knowledge, not generic driving competence alone.*

Evidence: Route hazard briefing record

COMMON REASONS FOR A PARTIAL ANSWER

- Training was completed once at hiring with no refresher since.
- No route-specific hazard briefing exists for regular corridors.

IMPLEMENTATION PLAN

When	What
Week 1	Review current driver training content and completion records.
Week 2	Build or source a patient-transport-specific driving course.

When	What
Week 3	Build route-specific hazard briefings and a refresher schedule.
Ongoing	Track refresher completion and update route briefings as needed.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Training completion review	Reviews driver training curriculum and completion records for all active drivers.

EVIDENCE BASE

National Fire Protection Association. NFPA 1917: Standard for Automotive Ambulances. Quincy (MA): NFPA; 2024.

2.4

Fatigue Management for Long-Distance Transport

CORE

A documented fatigue management policy governs maximum shift length and mandatory rest periods for crew on long-distance or inter-city transports, with actual shift records monitored against the policy.

In plain terms: There’s a real policy limiting how long crew can work without rest on long transports — and someone actually checks shift records against it, not just trusts crew to self-limit.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Fatigue is a well-documented contributor to both driving incidents and clinical error, and the risk is particularly acute in long-distance or inter-city transport where shifts can extend well beyond typical hospital-based schedules. A policy with vague language like “reasonable shift

length” provides no genuine limit, and without active monitoring against actual shift records, even a well-written policy can be quietly exceeded under operational pressure.

WHAT GOOD LOOKS LIKE • The policy states specific, defined hour limits, not vague language. • Actual shift records are checked against the policy, not just assumed compliant. • A documented instance exists of a shift being adjusted to prevent a breach.	COMMON FAILURE MODES • The policy uses vague language like “reasonable” with no specific limit. • Shift records exist but are never actually checked against the policy. • No example exists of the policy ever actually preventing a long shift.
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WORKED EXAMPLE

IN PRACTICE	
<i>A crew completing a long inter-city transport during a staffing shortage.</i>	
BEFORE	The fatigue policy stated shifts should be “reasonable in length,” with no specific hour limit. During a staffing shortage, a crew worked a sixteen-hour shift covering two long-distance transports back to back, with nobody flagging this as a policy concern since no specific limit existed to breach.
ACTION	The organization set a specific maximum shift length with mandatory rest periods, built a tracking system comparing actual shift records against the limit, and arranged a relief-crew contingency specifically for staffing shortage situations.

AFTER

The Monitor reviewed a recent instance where a scheduled shift was adjusted and relief crew called in specifically to prevent a fatigue policy breach, with the decision documented. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Set specific, defined hour limits in the fatigue policy, not vague language.
2. Build a system actually checking shift records against the limit.
3. Arrange a relief-crew contingency for staffing shortage situations.

The most common mistake: A fatigue policy written in vague terms like “reasonable shift length,” which provides no genuine, checkable limit and tends to erode under staffing pressure.

SELF-ASSESSMENT QUESTIONS

1. Does a written fatigue policy exist with specific, defined limits, not a vague expectation of “reasonable” shifts? — *Specific hour limits, not general language open to interpretation.*

Evidence: Written fatigue policy

2. Are actual shift records checked against the policy, or does the policy exist without monitoring? — *A policy with no monitoring mechanism rarely holds under operational pressure.*

Evidence: Shift record audit

3. Is there a documented instance of a shift being adjusted specifically to prevent a fatigue policy breach? — *Evidence the policy actually functions, not just exists on paper.*

Evidence: Shift adjustment record

COMMON REASONS FOR A PARTIAL ANSWER

- **The policy exists but uses vague, unenforceable language.**
- **No relief-crew contingency exists for staffing shortage situations.**

IMPLEMENTATION PLAN

When	What
Week 1	Set specific hour limits and rest requirements in the fatigue policy.
Week 2	Build a monitoring system checking shift records against the policy.
Week 3	Arrange a relief-crew contingency for shortage situations.
Ongoing	Review shift records monthly for policy adherence.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Shift record audit	Checks actual shift length records against the written fatigue policy's specific limits.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

2.5

Minimum Crew Complement Per Transport Type

STANDARD

A written policy defines the minimum crew complement — number and qualification mix — required for each transport acuity level, applied consistently regardless of staffing availability pressure.

In plain terms: The minimum number and mix of crew for each type of transport is written down and actually held to — including on nights and weekends when staffing is tightest.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Minimum crew complement policies most often erode quietly during off-hours staffing pressure — a night shift or weekend with fewer available staff is exactly when the temptation to proceed below minimum is strongest, and exactly when the consequences of doing so are least visible to management reviewing daytime operations. Consistent application specifically during these pressure points is what distinguishes a genuine policy from an aspirational one.

WHAT GOOD LOOKS LIKE • A written policy specifies crew numbers and qualification mix per acuity level. • Any below-minimum transport is logged and reviewed as a quality event. • The policy holds consistently across nights, weekends, and daytime hours.	COMMON FAILURE MODES • The policy exists but is understood informally and inconsistently by dispatchers. • Below-minimum transports happen during staffing pressure and go unlogged. • Off-hours staffing pressure consistently erodes the minimum in practice.
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WORKED EXAMPLE

IN PRACTICE <i>A weekend night shift with reduced crew availability.</i>	
BEFORE	The minimum crew complement policy was well understood and consistently followed on weekday daytime shifts, but on weekend nights, when fewer staff were available, dispatchers occasionally sent a single-crew transport below the stated minimum without any formal review of the decision.
ACTION	The organization required any below-minimum dispatch decision to be logged as a quality event with a named approver, regardless of time of day, and reviewed these logs specifically for off-hours patterns during management review.

AFTER

The Monitor reviewed quality event logs and found consistent application of the minimum complement policy across all shift times over the preceding quarter, with zero undocumented below-minimum dispatches. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether your minimum crew policy is written down with specific numbers, not informal understanding.
2. Build a logging requirement for any below-minimum dispatch decision.
3. Specifically review off-hours dispatch records for consistency.

The most common mistake: A minimum crew policy that holds reliably during well-staffed daytime shifts but quietly erodes during nights and weekends, precisely when staffing pressure is highest and oversight is lowest.

SELF-ASSESSMENT QUESTIONS

1. Does a written policy specify minimum crew numbers and qualification mix per acuity level? — *Not an informal norm understood differently by different dispatchers.*

Evidence: Written crew complement policy

2. Has a transport ever proceeded below the minimum complement due to staffing pressure? — *If so, was this logged and reviewed as a quality event, not quietly absorbed?*

Evidence: Quality event log

3. Is the minimum complement policy applied consistently across all shifts, including nights and weekends? — *Off-hours staffing pressure is a common, specific point where minimums quietly erode.*

Evidence: Off-hours dispatch record review

COMMON REASONS FOR A PARTIAL ANSWER

- The policy holds on weekdays but erodes during nights and weekends.
- Below-minimum dispatches happen but aren't consistently logged.

IMPLEMENTATION PLAN

When	What
Week 1	Formalize the minimum crew complement policy in writing.
Week 2	Build a logging requirement for below-minimum dispatch decisions.
Week 3	Brief all dispatchers, particularly for off-hours shifts.
Ongoing	Review off-hours dispatch logs specifically during management review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Dispatch log review	Reviews dispatch records specifically for off-hours and weekend consistency against the minimum policy.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

← Medical Transport Standards — all standards

Standard 3 — Patient Assessment & Fitness for Transport →

ASF STANDARDS · MEDICAL TRANSPORT · STANDARD 3

Standard 3 — Patient Assessment & Fitness for Transport

5 criteria · 3 non-negotiable · 2 core · Version 1.0

CRITERIA IN THIS STANDARD

3.1 — Pre-Transport Clinical Assessment Completed

3.2 — Transport-Level Classification Matches Patient Need

3.3 — Continuous Monitoring Appropriate to Acuity

3.4 — Deterioration Recognition and Response

3.5 — Patient Consent and Information Obtained

3.1 Pre-Transport Clinical Assessment Completed

NON-NEGOTIABLE

Every patient receives a documented clinical assessment confirming fitness for transport before departure, performed by qualified crew, not inferred from the sending facility's referral paperwork alone.

In plain terms: Crew actually look at and assess the patient themselves before leaving — not just trusting that the referral paperwork still reflects the patient's current state.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

The time gap between a sending facility completing referral paperwork and transport crew actually arriving can range from minutes to hours, during which a patient's clinical status can meaningfully change. Referral paperwork reflects the patient's condition at the moment it was written, not necessarily the moment of pickup, which is exactly why a fresh, hands-on assessment by the crew who will actually be responsible during transport is the genuine safeguard.

WHAT GOOD LOOKS LIKE

- A hands-on assessment is actually performed by crew before departure.
- The assessment is documented, not performed informally with no record.
- A documented instance exists of a transport being delayed or declined based on it.

COMMON FAILURE MODES

- Crew review sending paperwork but don't perform an independent hands-on check.
- An assessment happens but leaves no documented record.
- No example exists of the assessment ever actually changing the transport plan.

WORKED EXAMPLE

IN PRACTICE

A patient transfer with a two-hour gap between referral and crew arrival.

BEFORE

Crew arrived at the sending facility, reviewed the referral paperwork completed two hours earlier, and proceeded directly to loading the patient without an independent clinical check of current status.

ACTION

The organization built a mandatory pre-departure assessment checklist requiring crew to independently check vital signs and clinical status against the referral paperwork before loading,

with any meaningful discrepancy triggering a call back to the sending clinician.

AFTER

The Monitor reviewed a recent transport record showing crew identified a vital sign change from the referral paperwork during their independent assessment, which triggered a brief delay for sending-facility clinician review before departure. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether crew currently perform an independent assessment, or just review paperwork.
2. Build a mandatory pre-departure assessment checklist.
3. Define what discrepancy from referral paperwork triggers escalation before departure.

The most common mistake: Treating a review of the sending facility's referral paperwork as equivalent to an independent clinical assessment, when the patient's condition may have genuinely changed in the interval since that paperwork was completed.

SELF-ASSESSMENT QUESTIONS

1. Is a hands-on assessment actually performed by transport crew before departure, not just a review of sending paperwork? — *A patient's condition can change between referral and pickup; paperwork alone doesn't capture that.*

Evidence: Pre-departure assessment record

2. Is the assessment documented, not just performed informally with no record? — *An undocumented assessment leaves no basis for later review if something goes wrong.*

Evidence: Documented assessment record

3. Is there a documented instance of a transport being delayed or declined based on this assessment? — *Evidence the assessment genuinely functions as a gate, not a formality.*

Evidence: Delay or decline record

COMMON REASONS FOR A PARTIAL ANSWER

- Crew review paperwork thoroughly but skip an independent hands-on check.
- Assessment happens but isn’t consistently documented.

IMPLEMENTATION PLAN

When	What
Week 1	Observe current pre-departure practice for independent assessment.
Week 2	Build a mandatory assessment checklist and documentation requirement.
Week 3	Define escalation criteria for discrepancies found.
Ongoing	Review assessment records periodically for completeness.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Assessment record review	Checks for documented, independent pre-departure assessments distinct from referral paperwork.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

3.2 Transport-Level Classification Matches Patient Need

NON-NEGOTIABLE

Each transport is classified by required care level — basic, advanced, critical care — based on the patient’s actual clinical needs, with the assigned vehicle, crew, and equipment matching that classification before departure.

In plain terms: The transport is classified by what the patient actually needs clinically — and the vehicle, crew, and equipment assigned genuinely match that, not just whatever happened to be available.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Classification exists to translate a patient’s clinical need into a concrete resource requirement — vehicle, crew, equipment — and when this process is driven by resource convenience rather than genuine clinical assessment, the translation breaks down silently. A classification decision made hours before departure also needs to be revisited if the patient’s condition changes, since an earlier classification can become inaccurate by the time the transport actually happens.

WHAT GOOD LOOKS LIKE

- Classification is based on documented clinical assessment, not convenience.
- Any mismatch between classification and available resources has documented resolution.
- Classification is reassessed if patient condition changes before departure.

COMMON FAILURE MODES

- The available vehicle is assigned first, with classification adjusted to fit it.
- A resource mismatch proceeds without documented resolution.
- An earlier classification isn’t revisited even when condition clearly changes.

WORKED EXAMPLE

IN PRACTICE

A patient whose condition worsened between classification and actual departure.

BEFORE

A patient was classified as requiring basic-level transport at the time of booking, four hours before departure. By departure time, the patient’s condition had worsened, but the original

	classification and assigned basic-level crew remained unchanged since nobody reassessed it.
ACTION	The organization built a classification reconfirmation step immediately before departure, specifically checking whether anything had changed since the original booking classification.
AFTER	The Monitor reviewed a recent transport where the reconfirmation step caught a condition change, triggering reassignment to an advanced-level crew before departure. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether classification is based on documented clinical assessment or resource convenience.
2. Build a pre-departure reconfirmation step for classification.
3. Define how resource mismatches get documented and resolved.

The most common mistake: A classification made at booking time is treated as fixed, with no reconfirmation immediately before departure even when hours have passed and the patient's condition may have changed.

SELF-ASSESSMENT QUESTIONS

1. Is classification based on a documented clinical assessment, not a default or convenience-driven assignment? — *Assigning the available vehicle rather than the clinically appropriate one is a specific, checkable risk.*

Evidence: Classification assessment record

2. Where a mismatch between classification and available resources occurs, is there a documented escalation or resolution? — *Not proceeding with a mismatch simply because nothing better was available.*

Evidence: Mismatch resolution record

3. Is classification reassessed if the patient's condition changes before departure? — *A classification made hours earlier may no longer*

reflect current patient status.
Evidence: Reconfirmation record

COMMON REASONS FOR A PARTIAL ANSWER

- **Classification happens once at booking with no pre-departure reconfirmation.**
- **Resource mismatches proceed without a documented resolution process.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current classification process for clinical-assessment basis.
Week 2	Build a pre-departure reconfirmation step.
Week 3	Define mismatch escalation and resolution process.
Ongoing	Review classification-to-outcome matching periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Classification record review	Checks classification basis and any pre-departure reconfirmation against patient condition changes.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

3.3 Continuous Monitoring Appropriate to Acuity

NON-NEGOTIABLE

Patient vital signs and clinical status are monitored continuously throughout transport at a frequency appropriate to acuity, with monitoring results documented at regular intervals, not only at departure and arrival.

In plain terms: The patient is genuinely watched throughout the whole trip, with real checks recorded along the way — not just a snapshot at the start and another at the end.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Two data points — departure and arrival — capture nothing about what happened in between, which is precisely where a deteriorating trend would first become visible. For longer inter-city transports in particular, meaningful clinical change can develop gradually over the journey, and only genuine interval monitoring gives crew the chance to catch it while there's still time to respond appropriately.

WHAT GOOD LOOKS LIKE

- Vital signs are actually recorded at intervals throughout, not just start and end.
- Monitoring frequency genuinely scales higher for higher-acuity transports.
- Monitoring equipment matching the classification level is on board and functioning.

COMMON FAILURE MODES

- Only two data points exist — departure and arrival — missing the interval.
- One fixed monitoring interval is applied regardless of actual acuity.
- Classification says critical care but monitoring equipment doesn't match.

WORKED EXAMPLE

IN PRACTICE

A two-hour inter-city critical care transport.

BEFORE

Vital signs were recorded at departure and again at arrival, with no interval documentation during the two-hour journey, despite the patient's critical acuity classification requiring much closer observation.

ACTION	The organization built acuity-scaled monitoring intervals into the documentation requirement — every five minutes for critical care, every fifteen for advanced, every thirty for basic — with a physical reminder system in the vehicle.
AFTER	The Monitor reviewed a recent critical care transport record and found vital signs documented every five minutes throughout the full journey, matching the required interval. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check current transport records — are there interval data points, or just start/end?
2. Build specific, acuity-scaled monitoring intervals.
3. Confirm monitoring equipment on board matches each classification level.

The most common mistake: Treating departure and arrival vital signs as sufficient documentation, missing the interval data that would actually reveal a developing trend during a longer transport.

SELF-ASSESSMENT QUESTIONS

1. Are vital signs actually recorded at intervals throughout transport, not just at the start and end? — *Monitoring that exists only as two data points misses deterioration occurring in between.*

Evidence: Interval vital sign documentation

2. Does monitoring frequency genuinely scale with acuity, higher for critical transports? — *One fixed interval applied regardless of patient acuity doesn't reflect real clinical risk.*

Evidence: Acuity-scaled monitoring policy

3. Is monitoring equipment appropriate to the classification level actually on board and functioning? — *A critical care classification without matching monitoring capability is a direct mismatch.*

Evidence: Equipment-classification match check

COMMON REASONS FOR A PARTIAL ANSWER

- Only departure and arrival vitals are documented.

- One fixed monitoring interval is used regardless of acuity.

IMPLEMENTATION PLAN

When	What
Week 1	Audit recent transport records for interval monitoring completeness.
Week 2	Build acuity-scaled monitoring interval requirements.
Week 3	Confirm equipment-classification matching across the fleet.
Ongoing	Spot-check interval documentation on recent transports.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Transport record review	Checks for genuine interval vital sign documentation, not just departure/arrival points.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

3.4 Deterioration Recognition and Response

CORE

Crew are trained to recognize clinical deterioration during transport using a defined, scored assessment tool, with a documented response procedure including diversion to the nearest appropriate facility when needed.

In plain terms: Crew use a real, structured tool to catch early warning signs of deterioration — not just gut feeling — and know exactly when that means diverting instead of continuing.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Informal clinical impression is genuinely less reliable than a structured, scored tool for catching early deterioration, particularly for crew under the time pressure and stress of an active transport. The decision of whether to divert versus continue to the planned destination needs to be one crew can make instantly and confidently — hesitation in a genuine emergency costs exactly the time margin that often determines outcome.

WHAT GOOD LOOKS LIKE

- A defined, scored deterioration tool is actually used, not informal impression.
- A documented instance exists of a diversion decision made based on deterioration.
- Crew know diversion criteria without hesitation.

COMMON FAILURE MODES

- Deterioration recognition relies on individual clinical impression alone.
- No example exists of the diversion procedure actually being used.
- Crew hesitate or need to look up criteria when asked directly.

WORKED EXAMPLE

IN PRACTICE

A patient showing early signs of deterioration during a long-distance transport.

BEFORE

Crew relied on general clinical impression to judge deterioration, with no structured scoring tool. A patient's subtle but real deterioration during a long transport was noticed later than it might have been with a formal tool, though the outcome was ultimately fine.

ACTION

The organization adopted a standardized early-warning scoring tool for transport use, trained all crew on it, and built clear diversion criteria tied directly to specific score thresholds.

AFTER

The Monitor reviewed a subsequent transport where the scoring tool flagged deterioration early, and crew diverted to the nearest appropriate facility within minutes, with the decision clearly

documented against the score threshold.
Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Adopt a recognized, scored deterioration tool appropriate to transport use.
2. Train all crew on the tool and specific diversion criteria.
3. Drill the stop-versus-divert decision so crew can act without hesitation.

The most common mistake: Relying on individual crew clinical impression rather than a structured, scored tool, which is less consistent and can delay recognition of a genuine deterioration trend.

SELF-ASSESSMENT QUESTIONS

1. Is a defined, scored deterioration tool actually used, not just informal clinical impression? — *A structured tool catches early deterioration more reliably than impression alone.*

Evidence: Deterioration tool documentation

2. Is there a documented instance of a diversion decision made based on deterioration during transport? — *Evidence the response procedure functions in a genuine clinical situation.*

Evidence: Diversion record

3. Do crew know, without hesitation, the criteria that trigger diversion versus continuing to the planned destination? — *Hesitation in a real emergency costs time that matters.*

Evidence: Crew interview

COMMON REASONS FOR A PARTIAL ANSWER

- A tool exists but crew aren't fully trained or confident using it.
- Diversion criteria exist but crew need to consult a document to recall them.

IMPLEMENTATION PLAN

When	What
Week 1	Select and adopt a recognized scored deterioration tool.

When	What
Week 2	Train all crew on the tool and specific diversion criteria.
Week 3	Run a tabletop drill on the stop-versus-divert decision.
Ongoing	Refresh training periodically and review any actual diversion event.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Crew knowledge check	Asks crew to describe diversion criteria without consulting a document.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

3.5 Patient Consent and Information Obtained CORE

Patient or authorized representative consent for transport is obtained and documented before departure, with the patient informed in understandable terms of the transport plan and destination, and their right to decline transport genuinely honoured.

In plain terms: The patient’s actual consent is documented before leaving, and they’re told in plain terms where they’re going and why — not just assumed from the sending facility’s referral.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

A sending facility's referral reflects a clinical decision made by that facility's staff, not the patient's own documented consent to be transported — these are genuinely distinct, and treating the referral as a substitute for consent overlooks the patient's own role in the decision. For a vulnerable or disoriented patient especially, being moved without basic explanation of where and why can itself be distressing, independent of the clinical reason for transport.

WHAT GOOD LOOKS LIKE

- Consent is actually documented, distinct from sending facility referral paperwork.
- A real process exists for obtaining consent from an authorized representative when needed.
- The patient is told the destination and basic plan in understandable terms.

COMMON FAILURE MODES

- Consent is assumed from the sending facility's referral alone.
- No real alternative process exists for patients unable to consent directly.
- The patient is moved with no explanation of where or why.

WORKED EXAMPLE

IN PRACTICE

An elderly patient being transferred between facilities.

BEFORE

Transport proceeded based entirely on the sending facility's referral paperwork, with no separate consent documentation and no explanation given to the patient about where she was being taken, leaving her visibly confused and anxious during the journey.

ACTION

The organization built a consent and explanation step into the pre-departure process, requiring crew to document consent separately from referral paperwork and to explain the destination and basic plan to the patient in plain language.

AFTER

The Monitor reviewed a recent transport record showing documented consent distinct from the referral, with a note confirming the patient was

told the destination before departure. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether consent is documented separately from sending facility referral.
2. Build an alternative consent process for patients unable to consent directly.
3. Build a simple pre-departure explanation step for the patient.

The most common mistake: Treating the sending facility's clinical referral decision as equivalent to the patient's own documented consent, when these represent genuinely different things.

SELF-ASSESSMENT QUESTIONS

1. Is consent actually documented, not simply assumed from the patient's presence or sending facility referral? — *A referral from the sending facility is not the same as the patient's own documented consent.*

Evidence: Separate consent documentation

2. For a patient unable to consent directly, is there a documented process for obtaining consent from an authorized representative? — *A real, written alternative, not an exception that defaults to no consent process.*

Evidence: Alternative consent procedure

3. Is the patient told the destination and basic transport plan in understandable terms? — *Transport without basic explanation can be disorienting and distressing, especially for vulnerable patients.*

Evidence: Pre-departure explanation record

4. Is the patient's right to decline transport explicitly stated and genuinely honoured, with crew able to describe what happens when exercised? — *A real, honoured right, not an assumption that a scheduled transport obligates the patient to go.*

Evidence: Crew interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Consent is assumed from referral paperwork rather than separately documented.**

- No explanation step exists for informing the patient before departure.

IMPLEMENTATION PLAN

When	What
Week 1	Review current consent documentation practice.
Week 2	Build separate consent documentation and an authorized-representative process.
Week 3	Build a pre-departure patient explanation step.
Ongoing	Spot-check consent documentation on recent transports.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Consent record review	Checks for documented consent distinct from sending facility referral paperwork.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

← Medical Transport Standards — all standards

Standard 4 — Handover & Communication →

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ASF STANDARDS · MEDICAL TRANSPORT · STANDARD 4

Standard 4 — Handover & Communication

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

CRITERIA IN THIS STANDARD

4.1 — Structured Handover at Pickup

4.2 — Structured Handover at Destination

4.3 — Real-Time Status Communication to Dispatch

4.4 — Written Documentation Accompanies Patient

4.5 — Language-Appropriate Communication with Patient

4.1 Structured Handover at Pickup

NON-NEGOTIABLE

A structured, standardized handover is conducted between sending facility staff and transport crew at pickup, covering clinical status, treatment given, allergies, and specific concerns, not an informal verbal summary.

In plain terms: Crew get a real, structured briefing from sending staff covering everything that matters — not a quick, informal rundown that varies depending on who happens to be handing over.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

An unstructured verbal handover depends entirely on what the handing-over staff member happens to think to mention in the moment, which means critical details — a specific allergy, a recent medication change — can be omitted simply because they weren't top of mind during a brief exchange. A standardized format forces coverage of the specific categories most likely to matter clinically, regardless of who is giving or receiving the handover.

WHAT GOOD LOOKS LIKE

- A standardized format is actually used, not a verbal summary that varies by staff member.
- Allergies and specific concerns are covered explicitly, not folded into general diagnosis.
- The handover is documented with both parties' acknowledgment.

COMMON FAILURE MODES

- Handover quality depends heavily on which staff member is giving it.
- Allergies get mentioned only if the handing-over staff member happens to recall them.
- No documentation exists confirming the handover actually occurred.

WORKED EXAMPLE

IN PRACTICE

A sending facility with high staff turnover and no standard handover format.

BEFORE

Handover quality varied significantly by which sending facility staff member happened to be available. A new nurse once omitted a documented medication allergy during a verbal handover, which only came to light when crew separately reviewed the chart.

ACTION

The transport organization introduced a standardized handover card with required fields — allergies, current medications, treatment given,

specific concerns — that both sending staff and crew complete and sign together before departure.

AFTER

The Monitor reviewed recent handover cards and found consistent, complete coverage of all required fields with both parties' signatures, regardless of which sending facility staff member was involved. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a standardized handover card or checklist with required fields.
2. Require both parties to complete and sign it together, not just crew alone.
3. Pilot it with a sending facility partner and refine based on gaps found.

The most common mistake: Relying on an informal verbal handover whose completeness depends heavily on which individual staff member happens to be giving it, rather than a standardized format that forces coverage regardless of who's involved.

SELF-ASSESSMENT QUESTIONS

1. Is a standardized handover format actually used, not a verbal summary that varies by who's handing over? — *An unstructured handover risks omitting critical details depending on who's speaking.*
Evidence: Handover card or checklist
2. Does the handover cover allergies and specific concerns explicitly, not just general diagnosis? — *These are commonly the details lost in an informal handover.*
Evidence: Completed handover record
3. Is the handover documented, with both parties' acknowledgment? — *An undocumented handover leaves no record if information was missed.*
Evidence: Signed handover record

COMMON REASONS FOR A PARTIAL ANSWER

- A format exists but isn't consistently used by all sending facility partners.
- Handover happens but only one party signs or acknowledges it.

IMPLEMENTATION PLAN

When	What
Week 1	Build a standardized handover card with required fields.
Week 2	Pilot with one or two sending facility partners.
Week 3	Refine based on pilot feedback and roll out broadly.
Ongoing	Audit handover card completeness periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Handover record review	Checks completed handover cards for consistency and both-party acknowledgment.

EVIDENCE BASE

World Health Organization. Communication During Patient Hand-Over. Patient Safety Solutions, Volume 1, Solution 3. Geneva: WHO; 2007.

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

4.2 Structured Handover at Destination

NON-NEGOTIABLE

A structured handover is conducted between transport crew and receiving facility staff at arrival, covering changes in status during transport, interventions performed en route, and current clinical status, with receiving staff acknowledgment.

In plain terms: At arrival, receiving staff get a real briefing specifically on what happened during the trip — not just a repeat of what the sending facility already said.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Receiving staff already have access to the sending facility’s own records in most cases — what they genuinely need from crew is specifically what happened during the transport itself, information that exists nowhere else. A handover that simply repeats the pickup information without adding transport-specific detail misses the one thing only crew can actually report.

WHAT GOOD LOOKS LIKE

- The handover specifically covers what changed during transport.
- Receiving staff provide documented acknowledgment of the handover.
- Handover goes directly to a responsible clinician, not whoever is nearby.

COMMON FAILURE MODES

- The handover repeats pickup information without transport-specific detail.
- No acknowledgment record confirms the handover was actually received.
- Handover is given to whichever staff member happens to be present.

WORKED EXAMPLE

IN PRACTICE	
<i>An inter-city transport where the patient required an intervention en route.</i>	
BEFORE	At arrival, crew gave receiving staff a brief summary that largely repeated what was already in the sending facility’s transfer paperwork, without clearly flagging that an oxygen intervention had been needed partway through the journey.
ACTION	The organization built a destination handover format specifically structured around “what

changed during transport,” requiring crew to lead with any intervention or status change rather than repeating baseline information.

AFTER

The Monitor reviewed a recent destination handover record and found the oxygen intervention clearly flagged as the lead item, with documented acknowledgment from the receiving nurse. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a destination handover format specifically structured around transport changes.
2. Require documented receiving-staff acknowledgment.
3. Confirm handover goes to a named, responsible clinician, not whoever is nearby.

The most common mistake: A destination handover that largely repeats pickup information, missing the opportunity to clearly flag the transport-specific changes that only crew can actually report.

SELF-ASSESSMENT QUESTIONS

1. Does the destination handover specifically cover what changed during transport, not just a repeat of the pickup information? — *Transport-specific changes are exactly what receiving staff most need and often don't get.*

Evidence: Destination handover record

2. Is there documented acknowledgment from receiving staff that handover was received? — *Without acknowledgment, there's no confirmation the information actually transferred.*

Evidence: Receiving staff acknowledgment

3. Is the handover given directly to a responsible clinician, not left with whoever happens to be nearby? — *A handover to the wrong person functions the same as no handover.*

Evidence: Named recipient on handover record

COMMON REASONS FOR A PARTIAL ANSWER

- **Handover repeats baseline information without highlighting transport-specific changes.**

- No clear process ensures handover reaches a specifically responsible clinician.

IMPLEMENTATION PLAN

When	What
Week 1	Build a destination handover format focused on transport-specific changes.
Week 2	Train crew on leading with changes, not repeating baseline information.
Week 3	Build a documented acknowledgment requirement.
Ongoing	Spot-check destination handover records for transport-specific content.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Destination handover record review	Checks for transport-specific content and documented receiving-staff acknowledgment.

EVIDENCE BASE

World Health Organization. Communication During Patient Hand-Overs. Patient Safety Solutions, Volume 1, Solution 3. Geneva: WHO; 2007.

4.3

Real-Time Status Communication to Dispatch

CORE

Crew communicate transport status to dispatch at defined checkpoints throughout the journey, with a documented escalation procedure if expected communication is missed.

In plain terms: Dispatch actually hears from crew at set points throughout the trip — and if an expected check-in doesn’t come, something real happens about it.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Communication only at departure and arrival leaves a long gap during which a problem — vehicle breakdown, patient deterioration, a crew member in distress — could develop with nobody at dispatch aware anything is wrong. Checkpoint communication closes this gap, but only if a missed checkpoint actually triggers a response; otherwise the checkpoint system provides an illusion of oversight without the substance.

WHAT GOOD LOOKS LIKE

- Checkpoint communications actually happen at defined intervals.
- A documented procedure exists for what dispatch does when a checkpoint is missed.
- A documented instance exists of this escalation procedure actually being used.

COMMON FAILURE MODES

- Communication happens only at departure and arrival, no interim checkpoints.
- A missed checkpoint has no defined dispatch response.
- No example exists of the escalation procedure ever actually triggering.

WORKED EXAMPLE

IN PRACTICE

An inter-city transport losing cellular coverage for an extended period.

BEFORE

Dispatch expected a mid-route check-in that didn't arrive due to a coverage gap. With no defined escalation procedure, dispatch simply waited, uncertain whether this reflected a coverage issue or something more serious, for over an hour before taking any action.

ACTION

The organization built a specific escalation procedure: a missed checkpoint triggers an attempt via backup communication method within ten minutes, and if that also fails, a defined follow-up protocol including last-known-location tracking.

AFTER

The Monitor reviewed a subsequent instance where a missed checkpoint triggered the backup communication attempt within the required window, successfully reaching crew and confirming they were simply in a coverage gap. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Set specific checkpoint intervals appropriate to typical route lengths.
2. Build a defined, time-bound escalation procedure for missed checkpoints.
3. Test the escalation procedure, don't just document it.

The most common mistake: A missed checkpoint communication is met with uncertain waiting rather than a defined, immediate escalation procedure, leaving dispatch unsure how long to wait before taking action.

SELF-ASSESSMENT QUESTIONS

1. Are checkpoint communications actually happening at defined intervals, not only at departure and arrival? — *Without interim checkpoints, a problem mid-route can go unnoticed for a long period.*
Evidence: Checkpoint communication log
2. Is there a documented procedure for what dispatch does when an expected checkpoint communication doesn't arrive? — *A missed checkpoint with no follow-up defeats the purpose of checkpoint communication.*
Evidence: Written escalation procedure
3. Is there a documented instance of this escalation procedure actually being used? — *Evidence the procedure functions, not just exists on paper.*
Evidence: Escalation event record

COMMON REASONS FOR A PARTIAL ANSWER

- Checkpoints exist but a missed one has no defined response.
- The escalation procedure has never actually been tested or used.

IMPLEMENTATION PLAN

When	What
Week 1	Set defined checkpoint intervals for typical route types.
Week 2	Build a time-bound escalation procedure for missed checkpoints.
Week 3	Test the escalation procedure with a simulated missed checkpoint.
Ongoing	Review checkpoint adherence and escalation triggers periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Checkpoint and escalation log review	Reviews checkpoint communication logs and any escalation event record.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

4.4

Written Documentation Accompanies Patient

CORE

Complete written documentation — transport record, medications given, vital sign trends, any incidents — physically or digitally accompanies the patient to the receiving facility, not relying on verbal handover alone.

In plain terms: A real written record of the trip actually travels with the patient — not just whatever crew happened to say out loud at handover.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

Verbal handover, however thorough, is not retrievable later — a written record is what the receiving team can reference hours or days afterward if a question arises about what happened during transport. A record limited to final values at arrival loses the trajectory information that trend data over the journey actually provides, which can be clinically significant in its own right.

WHAT GOOD LOOKS LIKE

- Written documentation actually arrives with the patient, complete.
- Vital sign trends are included, not just final values.
- Incidents are clearly documented even if they resolved without lasting effect.

COMMON FAILURE MODES

- Documentation is sent separately and doesn't actually arrive with the patient.
- Only final vital sign values are recorded, losing trend information.
- A resolved incident is omitted since it "didn't end up mattering."

WORKED EXAMPLE

IN PRACTICE

A transport where documentation was meant to follow electronically.

BEFORE	Written transport records were meant to be uploaded electronically after each transport, but a system delay meant receiving staff sometimes had no written record available for several hours after the patient arrived, relying entirely on the verbal handover in the meantime.
ACTION	The organization required a printed or immediately accessible digital copy of the transport record to physically accompany the patient at handover, with the electronic upload as a backup rather than the primary delivery method.
AFTER	The Monitor confirmed recent transports all had a physical or immediately accessible record present at the moment of handover, not

dependent on a separate system upload.
Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Confirm documentation physically or immediately accompanies the patient, not sent separately.
2. Check whether vital sign trends are captured, not just final values.
3. Confirm resolved incidents are still documented, not omitted.

The most common mistake: Relying on a separate electronic upload system for documentation delivery, which can introduce a delay leaving receiving staff without a written record at the actual moment of handover.

SELF-ASSESSMENT QUESTIONS

1. Does written documentation actually arrive with the patient, not sent separately or left incomplete? — *Verbal handover alone is not a substitute for a written record the receiving team can reference later.*

Evidence: Transport record present at handover

2. Does the documentation include vital sign trends throughout transport, not just final values? — *A trend shows trajectory; a single final value does not.*

Evidence: Trend documentation

3. Are any incidents or interventions during transport clearly documented, not omitted if they resolved without lasting effect? — *Even a resolved incident is relevant clinical history for the receiving team.*

Evidence: Incident documentation

COMMON REASONS FOR A PARTIAL ANSWER

- Documentation delivery relies on a system with occasional delay.
- Resolved incidents are sometimes left out of the written record.

IMPLEMENTATION PLAN

When	What
Week 1	Review current documentation delivery timing against actual handover.

When	What
Week 2	Build a physical/immediate-access backup to any electronic system.
Week 3	Confirm trend and incident documentation requirements are being met.
Ongoing	Spot-check documentation completeness and delivery timing.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Handover observation	Confirms written documentation is physically present at the point of handover.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

4.5 **Language-Appropriate Communication with Patient** STANDARD

Where crew and patient do not share a language, a practical communication method — phone interpretation, translation cards, or equivalent — is available and used during transport, not simply skipped due to practical difficulty.

In plain terms: When crew and patient don't share a language, there's a real way to communicate that actually gets used — not skipped because it felt too hard in the moment.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

A phone interpretation line that exists in the organization's resources but that crew have never actually used provides no real benefit to a patient during an actual transport — access on paper and genuine use in practice are different things. The gap between the two is usually about familiarity and friction: crew need to know exactly how to access the resource quickly, or it won't be used under the time pressure of an actual transport.

WHAT GOOD LOOKS LIKE

- A practical interpretation method is actually available on board, genuinely accessible.
- A documented instance exists of the method being used during an actual transport.
- Crew can describe how to access it without hesitation.

COMMON FAILURE MODES

- An interpretation resource exists in policy but is rarely actually used.
- No example exists of the resource ever being used in a real transport.
- Crew aren't confident or quick in knowing how to access it.

WORKED EXAMPLE

IN PRACTICE

A transport organization reviewing interpretation resource usage.

BEFORE

A phone interpretation line was available under the organization's vendor contract, but crew rarely used it in practice, finding the access process cumbersome, and often fell back on gesture-based communication for language-discordant patients.

ACTION

The organization simplified access to a single speed-dial button on the vehicle's communication device, briefed all crew directly, and tracked usage to confirm the resource was genuinely being used.

AFTER

The Monitor reviewed usage logs showing a clear increase in actual interpretation line use following the simplified access, and crew described the

access process confidently without hesitation.
Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check actual usage records for any interpretation resource, not just its existence.
2. Simplify access if crew find it cumbersome in practice.
3. Brief crew directly and confirm they can describe access confidently.

The most common mistake: Having an interpretation resource technically available through a vendor contract, but with access cumbersome enough that crew default to gesture-based communication instead of actually using it.

SELF-ASSESSMENT QUESTIONS

1. Is a practical interpretation method actually available on board, not just theoretically accessible? — *A phone interpreter line that's never actually used in practice functions the same as not having one.*

Evidence: Usage log

2. Is there a documented instance of this method being used during an actual transport? — *Evidence the resource is genuinely used, not just available.*

Evidence: Usage record

3. Can crew describe how to access the interpretation method without hesitation? — *If crew don't know how to access it quickly, it won't be used under time pressure.*

Evidence: Crew interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A resource exists but access is cumbersome enough to discourage real use.**
- **Crew know the resource exists but hesitate on how to access it quickly.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current interpretation resource usage records.
Week 2	Simplify access if usage is low due to friction.
Week 3	Brief all crew directly on fast access.
Ongoing	Track usage to confirm the resource is genuinely used.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Crew access check	Asks crew to describe how to access interpretation during an actual transport without hesitation.

EVIDENCE BASE

World Health Organization Regional Office for Europe. Global Competency Standards for Refugee and Migrant Health. Copenhagen: WHO/Europe; 2024.

← Medical Transport Standards — all standards

Standard 5 — Infection Prevention & Control →

ASF STANDARDS · MEDICAL TRANSPORT · STANDARD 5

Standard 5 — Infection Prevention & Control

5 criteria · 3 non-negotiable · 2 core · Version 1.0

CRITERIA IN THIS STANDARD

5.1 — Vehicle Cleaned and Disinfected Between Patients

5.2 — Personal Protective Equipment Available and Used

5.3 — Isolation and Transmission-Risk Transport Protocol

5.4 — Sharps and Biohazard Waste Disposal

5.5 — Crew Exposure Incident Response

5.1 Vehicle Cleaned and Disinfected Between Patients

NON-NEGOTIABLE

The patient compartment and all contact surfaces are cleaned and disinfected according to a written protocol between every patient transport, with the cleaning actually completed and verifiable, not assumed from a general end-of-shift routine.

In plain terms: The vehicle gets genuinely cleaned and disinfected between every single patient — verified, not just assumed because the crew always clean up eventually.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

An end-of-shift cleaning routine, however thorough, leaves every patient transported earlier in that shift exposed to whatever the previous patient may have carried. Between-patient cleaning is the actual safeguard, and disinfectant contact time matters specifically — a quick wipe that doesn't allow the product to work for its required duration provides a false sense of having disinfected without the actual effect.

WHAT GOOD LOOKS LIKE

- Cleaning is verifiably completed between every patient, not assumed.
- The protocol specifies and crew observe required disinfectant contact time.
- A documented enhanced-cleaning process exists after known infectious transports.

COMMON FAILURE MODES

- Cleaning happens at end of shift rather than between each patient.
- A quick wipe doesn't meet the disinfectant's required contact time.
- No distinct enhanced protocol exists for known higher-risk transports.

WORKED EXAMPLE

IN PRACTICE

A busy crew completing multiple transports in one shift.

BEFORE

Between consecutive transports, crew did a quick visual wipe-down of obvious contact surfaces, with full disinfection reserved for end-of-shift, reasoning that a “proper clean” between every single patient wasn't practical given the pace of the day.

ACTION

The organization built a streamlined, genuinely between-patient protocol using a fast-acting disinfectant with a shorter required contact time, specifically designed to fit within realistic

turnaround windows, with a logged checklist required before the next patient boards.

AFTER

The Monitor reviewed cleaning logs across a busy shift and found each between-patient cleaning logged and completed within the disinfectant's required contact time. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether cleaning actually happens between every patient, not just at shift end.
2. Confirm the disinfectant's required contact time and whether crew actually observe it.
3. Build a logged checklist crew complete between every patient.

The most common mistake: Reserving full disinfection for end-of-shift and relying on a quick wipe-down between patients during a busy day, exposing every earlier patient in that shift to residual risk from prior transports.

SELF-ASSESSMENT QUESTIONS

1. Is cleaning actually completed between every patient, verifiable through a log or checklist, not assumed? — *Spot-checked against actual records, not taken on crew's word.*

Evidence: Between-patient cleaning log

2. Does the protocol specify contact time for disinfectant, not just a wipe-down? — *Disinfectants require a minimum contact time to be effective; a quick wipe often doesn't meet it.*

Evidence: Written cleaning protocol

3. Is there a documented process for enhanced cleaning after a known infectious transport? — *Standard between-patient cleaning may be insufficient after a known high-risk transport.*

Evidence: Enhanced cleaning protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Between-patient cleaning happens but doesn't meet required contact time.**

- No distinct enhanced protocol exists for known infectious transports.

IMPLEMENTATION PLAN

When	What
Week 1	Audit current between-patient cleaning practice against disinfectant requirements.
Week 2	Select a disinfectant with contact time matching realistic turnaround windows.
Week 3	Build a logged between-patient checklist and enhanced-cleaning protocol.
Ongoing	Spot-check cleaning logs for completion and contact-time compliance.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Cleaning log review	Checks between-patient cleaning logs for completion and disinfectant contact-time compliance.

EVIDENCE BASE

World Health Organization. Infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care. Geneva: WHO; 2014.

National Fire Protection Association. NFPA 1917: Standard for Automotive Ambulances. Quincy (MA): NFPA; 2024.

5.2 Personal Protective Equipment Available and Used

NON-NEGOTIABLE

Appropriate PPE is stocked on every vehicle in adequate supply, matched to the transport’s known or suspected infectious risk, and observed to be actually worn by crew during patient contact.

In plain terms: The right protective gear is genuinely on every vehicle and crew actually wear it during patient contact — observed directly, not just taken on trust.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

PPE compliance self-report is notoriously unreliable, since crew generally know the expected answer regardless of actual practice — direct observation is the only way to genuinely assess whether PPE use is a real habit under real conditions. A depleted PPE stock discovered mid-transport, rather than caught proactively, represents a preventable and specific failure that a routine check schedule exists to catch.

WHAT GOOD LOOKS LIKE

- PPE is observed being worn correctly during actual patient contact.
- Stock is checked and restocked on a fixed schedule, not discovered depleted.
- Higher-level PPE is available and used for known higher-risk transports.

COMMON FAILURE MODES

- PPE is available but not consistently worn, especially under time pressure.
- Stock depletion is discovered mid-shift rather than caught proactively.
- Only standard PPE is available even for known higher-risk transports.

WORKED EXAMPLE

IN PRACTICE	
<i>A crew responding to a routine transport during a busy shift.</i>	
BEFORE	PPE was generally available, but crew self-reported consistent use when asked, while direct observation during an unannounced check found inconsistent glove use specifically during quick, low-perceived-risk transports.
ACTION	The organization introduced periodic unannounced observation checks specifically

during real operations, not scheduled visits, and reinforced that PPE use applies to every patient contact regardless of perceived risk level.

AFTER

The Monitor conducted an unannounced observation during actual patient contact and found consistent, correct PPE use. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Observe actual patient contact directly, ideally unannounced, rather than relying on self-report.
2. Build a fixed PPE stock-check schedule.
3. Confirm higher-level PPE is available for known higher-risk transport types.

The most common mistake: Treating PPE use as less important for quick, low-perceived-risk transports, when the actual infectious risk doesn't necessarily correlate with how routine a transport feels.

SELF-ASSESSMENT QUESTIONS

1. Observe actual patient contact — is PPE being worn correctly for the situation? — *Observed directly, not self-reported, since compliance self-report is unreliable.*

Evidence: Direct observation

2. Is PPE stock checked and restocked on a fixed schedule, not discovered depleted mid-shift? — *A depleted PPE stock discovered during an actual transport is a specific, preventable failure.*

Evidence: Stock check log

3. Is higher-level PPE available and used for known or suspected higher-risk transports? — *Standard PPE may be insufficient for a known infectious case; escalated protection should be available.*

Evidence: Escalated PPE stock and usage record

COMMON REASONS FOR A PARTIAL ANSWER

- **PPE use is inconsistent for quick or low-perceived-risk transports.**

- Stock checks happen irregularly rather than on a fixed schedule.

IMPLEMENTATION PLAN

When	What
Week 1	Conduct an unannounced observation check of current PPE practice.
Week 2	Build a fixed PPE stock-check schedule.
Week 3	Confirm escalated PPE availability for higher-risk transport types.
Ongoing	Conduct periodic unannounced observation checks.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Patient contact observation	Directly observes actual patient contact for genuine, consistent PPE use.

EVIDENCE BASE

World Health Organization. Laboratory biosafety manual, 4th ed. Geneva: WHO; 2020.

5.3 Isolation and Transmission-Risk Transport Protocol

NON-NEGOTIABLE

A written protocol governs transport of patients with known or suspected transmissible infection, including crew PPE escalation, vehicle configuration, and advance notification to the receiving facility.

In plain terms: There's a real, specific plan for transporting a patient with a known or suspected infectious condition — including telling the receiving facility in advance so they're actually ready.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

On-board precautions alone protect the crew and current transport, but a receiving facility caught unprepared for an infectious arrival represents a separate, specific risk this protocol needs to address — advance notification gives the receiving team time to prepare appropriate isolation arrangements before the patient actually arrives. Crew needing to consult a document during an actual transmissible-risk situation represents exactly the kind of delay this protocol exists to prevent.

WHAT GOOD LOOKS LIKE

- The protocol specifically addresses advance notification, not just on-board precautions.
- Crew can describe the protocol's key steps without needing to look it up.
- A documented instance exists of the protocol being followed for an actual transport.

COMMON FAILURE MODES

- The protocol covers on-board precautions but omits receiving-facility notification.
- Crew need to consult a document to recall the protocol's steps.
- No example exists of the protocol actually being followed for a real case.

WORKED EXAMPLE

IN PRACTICE

A transfer involving a patient with a known transmissible infection.

BEFORE

On-board precautions were followed correctly, but the receiving facility wasn't notified in advance, arriving to discover the infectious status only at handover, with no isolation space prepared and a scramble to accommodate the patient appropriately.

ACTION

The organization built advance notification into the protocol as a required step, triggered as soon

as a transmissible risk is identified, well before departure, giving the receiving facility real lead time to prepare.

AFTER

The Monitor reviewed a subsequent case where advance notification was sent and the receiving facility had isolation arrangements ready before the patient arrived. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build advance notification into the isolation transport protocol as a required step.
2. Train crew on the protocol's key steps until they can describe them without a document.
3. Drill or walk through the protocol at least once.

The most common mistake: Building a thorough on-board precautions protocol while overlooking the equally important step of notifying the receiving facility in advance, leaving them unprepared at the moment of arrival.

SELF-ASSESSMENT QUESTIONS

1. Does the protocol specifically address advance notification to the receiving facility, not just on-board precautions? — *A receiving facility caught unprepared for an infectious arrival is a specific, preventable risk.*
Evidence: Written isolation transport protocol

2. Can crew describe the protocol's key steps without needing to look it up? — *In an actual situation, crew need to know this without delay.*
Evidence: Crew interview

3. Is there a documented instance of this protocol being followed for an actual transmissible-infection transport? — *Evidence the protocol functions in practice, not just on paper.*
Evidence: Case record

COMMON REASONS FOR A PARTIAL ANSWER

- **The protocol omits advance receiving-facility notification.**
- **Crew know a protocol exists but can't recall its specific steps unprompted.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the current protocol for advance notification coverage.
Week 2	Build the notification step if missing.
Week 3	Train crew until they can describe the protocol without a document.
Ongoing	Review any actual isolation transport case against the protocol.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Crew knowledge check	Asks crew to describe the isolation transport protocol's key steps without reference material.

EVIDENCE BASE

World Health Organization. Infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care. Geneva: WHO; 2014.

5.4 Sharps and Biohazard Waste Disposal

CORE

Sharps and biohazardous waste generated during transport are contained in appropriate on-board containers and disposed of through a licensed regulated pathway at the earliest point of return, never accumulated loosely or disposed of informally.

In plain terms: Sharps and biohazard waste go into real containers on board and get disposed of properly, through a licensed route — never left loose or thrown away informally.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

A missing or inaccessible sharps container during transport forces crew toward improvised, unsafe disposal in a moving vehicle — a risk considerably harder to manage than in a fixed clinical setting. Disposal through a genuinely licensed, documented pathway matters both for regulatory compliance and because an informal arrangement provides no real assurance about where biohazardous material actually ends up.

WHAT GOOD LOOKS LIKE

- Sharps containers are actually present and accessible on board, not left behind.
- Disposal is documented through a licensed, regulated pathway.
- Containers are replaced before reaching unsafe fill levels.

COMMON FAILURE MODES

- A container is left behind to save space on a smaller vehicle.
- Disposal relies on an informal, undocumented arrangement.
- Containers are used past safe fill levels before replacement.

WORKED EXAMPLE

IN PRACTICE

A smaller transport vehicle with limited storage space.

BEFORE

On a smaller vehicle used for less-equipped basic transports, a sharps container was sometimes left behind to save space, with crew planning to dispose of any sharps generated once back at base, which meant carrying loose sharps in the vehicle during the interim.

ACTION

The organization mandated a compact sharps container on every vehicle regardless of size, with no exceptions, and formalized a disposal contract with a licensed waste management company covering all vehicle types.

AFTER

The Monitor inspected the smaller vehicle and found a properly stocked sharps container present and accessible, with current disposal documentation. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check every vehicle, including smaller ones, for an actual sharps container present.
2. Confirm disposal is through a documented, licensed pathway.
3. Check current container fill levels for any approaching unsafe limits.

The most common mistake: Leaving a sharps container behind on a smaller or more space-constrained vehicle to save room, planning instead to handle disposal back at base, which means loose sharps are carried during the interim.

SELF-ASSESSMENT QUESTIONS

1. Are sharps containers actually present and accessible on board, not left behind to save space? — *A missing sharps container leads to unsafe improvised disposal during transport.*

Evidence: Vehicle inspection

2. Is disposal documented through a licensed pathway, not an informal arrangement? — *A disposal manifest or equivalent record, verifiable on request.*

Evidence: Disposal manifest

3. Are sharps containers replaced before reaching unsafe fill levels? — *An overfilled container in a moving vehicle is a specific, elevated risk.*

Evidence: Container fill-level inspection

COMMON REASONS FOR A PARTIAL ANSWER

- **Smaller vehicles sometimes lack a sharps container due to space constraints.**
- **Disposal documentation is incomplete for one or more vehicle types.**

IMPLEMENTATION PLAN

When	What
Week 1	Inspect every vehicle for sharps container presence, including smaller ones.
Week 2	Source compact containers for space-constrained vehicles if needed.
Week 3	Confirm or establish a licensed disposal contract covering all vehicles.
Ongoing	Spot-check container fill levels and disposal documentation.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Vehicle inspection	Checks every vehicle type for sharps container presence and appropriate fill level.

EVIDENCE BASE

World Health Organization. Safe management of wastes from health-care activities, 2nd ed. Geneva: WHO; 2014.
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5.5 Crew Exposure Incident Response

CORE

A written protocol governs crew response to a biological exposure incident during transport, including immediate first aid, reporting, and post-exposure medical follow-up, with the protocol accessible and known regardless of location during transport.

In plain terms: If a crew member has an exposure incident anywhere on a route, not just near base, they know exactly what to do and can actually get follow-up care.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

An exposure incident can happen anywhere along a route, not only conveniently near base, which means the response protocol and post-exposure follow-up need to genuinely function from any point a transport might reach. A referenced occupational health service that’s only practically reachable from near base leaves a crew member exposed during a distant inter-city transport without the real support the protocol is meant to provide.

WHAT GOOD LOOKS LIKE • Crew can describe first steps without consulting a document, from anywhere on a route. • Post-exposure medical follow-up is accessible from any typical route point. • A documented recent incident, or at minimum a drill, matches the written protocol.	COMMON FAILURE MODES • The protocol works well near base but has no plan for distant route points. • The referenced follow-up service is only practically reachable from base. • The protocol has never been drilled, only distributed as a document.
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WORKED EXAMPLE

IN PRACTICE <i>An inter-city route several hours from the organization’s base.</i>	
BEFORE	The exposure response protocol referenced a specific occupational health clinic near base, with no clear plan for a crew member exposed several hours away on a long inter-city route.
ACTION	The organization built a route-independent follow-up arrangement using a national occupational health network, with a protocol card listing the nearest participating facility for major regular routes, carried on board.

AFTER

The Monitor asked crew on a long-distance route to describe their exposure follow-up options and they correctly identified the nearest network facility for that specific route. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether the current follow-up arrangement works from distant route points, not just base.
2. Build a route-independent follow-up option, such as a broader network.
3. Ask crew on a longer route to describe their actual follow-up options.

The most common mistake: Building an exposure response arrangement around a single clinic near base, without considering that exposure incidents can happen anywhere along a route, including hours away during inter-city transport.

SELF-ASSESSMENT QUESTIONS

1. Can crew describe the protocol's first steps without consulting a document, including while away from base? — *An exposure can happen anywhere on a route, not only at base.*

Evidence: Crew interview

2. Is post-exposure medical follow-up accessible from any point on a typical route, not only near base? — *A referenced service that's only practically reachable from base doesn't serve a crew member exposed mid-route.*

Evidence: Follow-up network coverage

3. Is there a documented recent exposure incident, and did the response match the written protocol? — *Where none has occurred, confirm the protocol has at least been drilled.*

Evidence: Incident or drill record

COMMON REASONS FOR A PARTIAL ANSWER

- Follow-up arrangements only genuinely work from near base.
- The protocol has never been drilled for a distant-route scenario.

IMPLEMENTATION PLAN

When	What
Week 1	Review current follow-up arrangement for route-independence.
Week 2	Build a broader network or route-card solution if gaps exist.
Week 3	Run a drill scenario for a distant-route exposure.
Ongoing	Refresh crew knowledge periodically, including for less common routes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Route-specific crew interview	Asks crew on a specific route to describe their actual exposure follow-up options for that route.

EVIDENCE BASE

Centers for Disease Control and Prevention. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures. MMWR Recomm Rep. 2013;62(RR-10):1-19.

← Medical Transport Standards — all standards

Standard 6 — Emergency Response During Transport →

ASF STANDARDS · MEDICAL TRANSPORT · STANDARD 6

Standard 6 — Emergency Response During Transport

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

CRITERIA IN THIS STANDARD

6.1 — Cardiac Arrest / Life-Threatening Event Protocol

6.2 — Nearest Appropriate Facility Diversion Capability

6.3 — Vehicle Breakdown or Accident Contingency

6.4 — Mass Casualty / Multi-Patient Surge Plan

6.5 — Post-Incident Debrief and Review

6.1 Cardiac Arrest / Life-Threatening Event Protocol

NON-NEGOTIABLE

A written protocol governs crew response to cardiac arrest or other immediately life-threatening deterioration during transport, including whether to stop, continue, or divert, with crew trained and drilled on this decision-making, not improvising in the moment.

In plain terms: Crew know exactly what to do in a genuine cardiac arrest, including the stop-or-continue decision — drilled, not figured out in the moment under real pressure.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

The decision of whether to stop the vehicle to provide optimal resuscitation, continue toward the destination, or divert to a nearer facility carries genuine trade-offs that are difficult to reason through clearly during an actual cardiac arrest. A drilled response, where the decision logic has already been worked through and practiced, functions very differently under real stress than a document crew have only read.

WHAT GOOD LOOKS LIKE

- Crew describe the stop-versus-continue criteria without hesitation.
- The protocol has actually been drilled, not only distributed as a document.
- A documented instance exists of the protocol being followed, or a drill record.

COMMON FAILURE MODES

- Crew hesitate or give inconsistent answers when asked about the decision criteria.
- The protocol exists as a document that's been read but never practiced.
- No drill record or real event record exists to demonstrate the protocol functions.

WORKED EXAMPLE

IN PRACTICE

A transport organization reviewing its cardiac arrest response readiness.

BEFORE

A written protocol existed describing the stop-versus-continue decision, but it had never been drilled. When asked individually, different crew members gave inconsistent answers about when to stop versus continue toward the destination.

ACTION

The organization ran a scenario-based drill specifically on the stop-versus-continue decision, using realistic simulated situations, and repeated

this drill quarterly to maintain consistency across all crew.

AFTER

The Monitor asked three crew members individually about the decision criteria and received consistent, confident answers, and reviewed the quarterly drill schedule and completion records. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask several crew members individually about the stop-versus-continue decision criteria.
2. If answers are inconsistent, clarify and formalize the decision logic.
3. Run a scenario-based drill, not just document distribution.

The most common mistake: Distributing a written protocol and treating it as sufficient preparation, without ever actually drilling the decision through a realistic scenario, leaving the protocol untested until a genuine emergency occurs.

SELF-ASSESSMENT QUESTIONS

1. Can crew describe the stop-versus-continue decision criteria without hesitation? — *Hesitation in an actual cardiac arrest costs time that directly affects outcome.*

Evidence: Crew interview

2. Has this protocol actually been drilled, not only distributed as a document? — *A drilled response functions very differently under real stress than one only read about.*

Evidence: Drill record

3. Is there a documented instance of this protocol being followed during an actual event? — *Where none has occurred, confirm the drill record instead.*

Evidence: Event record or drill record

COMMON REASONS FOR A PARTIAL ANSWER

- **A protocol exists but has never been drilled through a realistic scenario.**

- Different crew members give inconsistent answers about decision criteria.

IMPLEMENTATION PLAN

When	What
Week 1	Interview crew individually to check decision-criteria consistency.
Week 2	Clarify and formalize the decision logic if gaps are found.
Week 3	Run a scenario-based drill for all crew.
Ongoing	Repeat the drill on a quarterly schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Individual crew interview	Asks crew members separately about decision criteria to check for genuine consistency.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

6.2 Nearest Appropriate Facility Diversion Capability

NON-NEGOTIABLE

Crew have real-time access to information on the nearest appropriate facility along any route, with a defined, practiced process for diverting there when a patient’s condition requires it, rather than continuing to the originally planned destination regardless.

In plain terms: Crew can quickly find and divert to the nearest genuinely appropriate facility if the patient needs it — and they can decide this themselves, without waiting on distant approval.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

A rigid commitment to the originally planned destination, regardless of how a patient's condition changes en route, overlooks the reality that the nearest appropriate facility can sometimes be the safer choice. A diversion decision that requires lengthy remote approval before crew can act undermines the entire purpose of having the capability — the value lies specifically in crew being able to act quickly based on their direct clinical assessment.

WHAT GOOD LOOKS LIKE

- Crew have actual, current nearby-facility information accessible en route.
- A documented instance exists of diversion actually occurring when needed.
- Crew can decide to divert directly, without needing distant approval first.

COMMON FAILURE MODES

- Facility information is outdated or requires a call back to dispatch to access.
- No example exists of diversion ever actually being used in practice.
- Diversion requires lengthy remote sign-off before crew can act.

WORKED EXAMPLE

IN PRACTICE

A long-distance transport where the patient's condition worsened significantly mid-route.

BEFORE

Crew had to call dispatch and wait for a supervisor's approval before diverting to a nearer facility, a process that took several minutes during an actual deteriorating situation, because the organization treated any deviation from the planned destination as requiring management sign-off.

ACTION

The organization redefined policy to give crew direct authority to divert based on their own clinical assessment, with notification to dispatch

happening simultaneously rather than as a prerequisite, and equipped vehicles with a real-time facility-mapping tool.

AFTER

The Monitor reviewed a subsequent diversion event where crew made and acted on the decision within two minutes, notifying dispatch simultaneously rather than waiting for approval. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether diversion currently requires remote approval before crew can act.
2. Give crew direct authority to divert based on clinical assessment.
3. Equip vehicles with current, accessible nearby-facility information.

The most common mistake: Requiring crew to obtain remote approval before diverting, treating any deviation from the planned destination as a management decision rather than trusting crew's direct clinical judgment in the moment.

SELF-ASSESSMENT QUESTIONS

1. Do crew have actual, current access to nearby facility information en route, not relying on memory or an outdated reference? — *Current, accessible information, not something that requires a call back to dispatch to look up.*

Evidence: Facility information tool or reference

2. Is there a documented instance of diversion actually occurring when needed? — *Evidence the capability functions in practice, not just exists in theory.*

Evidence: Diversion event record

3. Is the decision to divert made by crew directly, without needing to wait for distant approval that could cause dangerous delay? — *A diversion decision requiring lengthy remote sign-off undermines the purpose of having the capability.*

Evidence: Diversion decision policy

COMMON REASONS FOR A PARTIAL ANSWER

- Diversion requires remote approval, adding delay.
- Facility information isn’t genuinely current or easily accessible en route.

IMPLEMENTATION PLAN

When	What
Week 1	Review current diversion decision authority and approval requirements.
Week 2	Grant crew direct diversion authority based on clinical assessment.
Week 3	Equip vehicles with current facility information tools.
Ongoing	Review any diversion event for decision speed and appropriateness.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Diversion policy and event review	Checks diversion decision authority and reviews any actual diversion event for decision speed.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

6.3

Vehicle Breakdown or Accident Contingency

CORE

A written contingency plan covers vehicle breakdown or accident during a patient transport, including backup vehicle dispatch, patient safety measures, and notification protocols, tested at a defined interval.

In plain terms: There’s a real, tested plan for what happens if the vehicle breaks down or crashes mid-transport — specifically covering keeping the patient safe

and comfortable during the wait, not just getting a new vehicle there.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

A breakdown contingency plan focused purely on vehicle recovery logistics misses the most clinically relevant part of the scenario — what happens to the patient during the unplanned stop. Backup vehicle response time is a specific assumption that's often untested and can prove considerably more optimistic than reality, which only testing reveals.

WHAT GOOD LOOKS LIKE

- The plan specifically addresses patient safety during the breakdown period.
- Backup vehicle dispatch has actually been tested, with a known realistic response time.
- Crew know their specific role during a breakdown.

COMMON FAILURE MODES

- The plan focuses on vehicle recovery logistics, not patient safety during the wait.
- Backup response time is assumed rather than actually tested.
- Only management knows the plan exists; crew don't know their specific role.

WORKED EXAMPLE

IN PRACTICE	
<i>A breakdown contingency plan reviewed for the first time since it was written.</i>	
BEFORE	The plan covered calling a backup vehicle, assumed to arrive “promptly,” with no documented patient safety measures for the waiting period and no record of the plan ever being tested.
ACTION	The organization tested backup vehicle dispatch for real, discovering actual response time was twenty-two minutes rather than the assumed ten, revised the plan accordingly, and added specific

patient safety and comfort measures for the waiting period.

AFTER

The Monitor reviewed the test record showing realistic response time documentation and the patient safety measures now built into the plan, with crew able to describe their specific role. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add specific patient safety measures for the breakdown waiting period if missing.
2. Actually test backup vehicle dispatch to get a real response time.
3. Brief crew on their specific role during a breakdown.

The most common mistake: Assuming backup vehicle response time without ever actually testing it, which frequently proves considerably more optimistic than what a real test reveals.

SELF-ASSESSMENT QUESTIONS

1. Does the plan specifically address patient safety during the breakdown period, not just vehicle recovery logistics? — *Patient safety and comfort during an unplanned stop is the most clinically relevant part of this scenario.*

Evidence: Written contingency plan

2. Has backup vehicle dispatch actually been tested, with a known realistic response time? — *An untested assumption about backup response time often proves optimistic.*

Evidence: Test record

3. Do crew know their specific role during a breakdown, not just that a plan exists? — *A plan known only to management doesn't function during an actual roadside event.*

Evidence: Crew interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Backup response time is assumed rather than genuinely tested.**
- **The plan lacks specific patient safety measures for the waiting period.**

IMPLEMENTATION PLAN

When	What
Week 1	Review the current plan for patient safety measure coverage.
Week 2	Conduct a real backup vehicle dispatch test.
Week 3	Revise the plan based on test findings and brief crew on their role.
Ongoing	Re-test backup dispatch on a defined interval.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Plan and test record review	Reviews the contingency plan for patient safety content and checks for a genuine dispatch test record.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

6.4

Mass Casualty / Multi-Patient Surge Plan

CORE

Where the organization’s scope includes response to mass casualty or multi-patient events, a written surge plan covers resource allocation, triage coordination with other responders, and communication with receiving facilities.

In plain terms: If the organization actually responds to mass casualty events, there’s a real plan specific to its own operations — not a generic template, and not written in isolation from other responders.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Where applicable	Where applicable	Full

WHY THIS MATTERS

A generic mass casualty template, not adapted to the organization's actual fleet size, typical operating area, and real relationships with other responders, provides limited genuine readiness. Mass casualty events virtually always involve coordination across multiple organizations, which means a plan written in isolation, without reference to how other responders will actually be coordinating, misses the most operationally critical element.

WHAT GOOD LOOKS LIKE • The plan is specific to the organization's actual scope and operating area. • The plan specifically addresses coordination with other responders. • The plan has been exercised, even at a tabletop level, within a defined interval.	COMMON FAILURE MODES • A generic template is adopted without adaptation to actual operations. • The plan focuses only on internal resource allocation, not external coordination. • No exercise, even tabletop, has ever been conducted.
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WORKED EXAMPLE

IN PRACTICE	
<i>A regional transport organization with a generic mass casualty plan.</i>	
BEFORE	The organization's mass casualty plan was adapted from a generic industry template, with no reference to the organization's actual fleet size or any coordination arrangement with the regional fire service or other transport providers.
ACTION	The organization rewrote the plan specific to its actual resources and established a formal coordination agreement with the regional emergency management authority, then ran a tabletop exercise involving those partner organizations.
AFTER	The Monitor reviewed the revised plan, the coordination agreement, and the tabletop

exercise record showing genuine multi-organization participation. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether your current plan is adapted to your actual resources and area, not a generic template.
2. Build or formalize coordination arrangements with other regional responders.
3. Run at least a tabletop exercise with relevant partners.

The most common mistake: Adopting a generic industry-standard mass casualty template without adapting it to the organization's actual fleet size, typical operating area, and real relationships with other regional responders.

SELF-ASSESSMENT QUESTIONS

1. Is the plan specific to the organization's actual scope and typical operating area, not a generic template? — *A plan written for a different context than the organization's real operations is of limited practical use.*

Evidence: Written surge plan

2. Does the plan specifically address coordination with other responders, not just internal resource allocation? — *A mass casualty event rarely involves this organization alone.*

Evidence: Coordination agreement or arrangement

3. Has the plan been exercised, even at a tabletop level, within a defined interval? — *An untested surge plan frequently reveals gaps only once genuinely tested.*

Evidence: Exercise record

COMMON REASONS FOR A PARTIAL ANSWER

- The plan is a generic template not adapted to actual operations.
- No formal coordination exists with other regional responders.

IMPLEMENTATION PLAN

When	What
Week 1	Review the current plan against actual organizational resources.

When	What
Week 2	Establish or formalize coordination arrangements with other responders.
Week 3	Plan and schedule a tabletop exercise.
Ongoing	Exercise the plan on a defined interval with partner organizations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Plan and exercise review	Reviews the surge plan's specificity and checks for a genuine exercise record involving other responders.

EVIDENCE BASE

World Health Organization. Mass Casualty Management Systems: Strategies and guidelines for building health sector capacity. Geneva: WHO; 2007.

6.5 Post-Incident Debrief and Review

STANDARD

Following any significant clinical event, breakdown, or diversion during transport, a structured debrief is conducted with involved crew, with findings feeding into the organization's corrective action process.

In plain terms: After anything significant happens, the crew actually talk it through properly — and what they find genuinely leads to real changes, not just a conversation that goes nowhere.

Transport category	Standalone MTO	Hospital-operated	Ambulance service
Applicability	Full	Full	Full

WHY THIS MATTERS

A near-miss with a fine outcome still carries genuine lessons, but these are easily lost if debriefs happen only after events with poor outcomes. The real value of a debrief lies specifically in its connection to

corrective action — an insightful conversation that never translates into an actual process change has captured the lesson without acting on it, which means the same situation can recur.

WHAT GOOD LOOKS LIKE • A debrief is actually conducted after significant events, including near-misses. • Debrief findings genuinely feed into corrective action, with traceable follow-through. • The debrief environment is genuinely blameless, encouraging honest input.	COMMON FAILURE MODES • Debriefs happen only after events with poor outcomes, not near-misses. • Findings stay as an informal conversation with no link to corrective action. • A punitive debrief environment discourages honest, complete accounts.
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WORKED EXAMPLE

IN PRACTICE	
<i>A near-miss where a scheduling error nearly resulted in an acuity mismatch.</i>	
BEFORE	A dispatch error nearly sent a basic-level crew on a critical-acuity transport, caught just before departure. Because the outcome was ultimately fine, no formal debrief occurred, and the scheduling process gap that allowed the near-miss remained unaddressed.
ACTION	The organization extended its debrief requirement explicitly to near-misses, not only events with actual poor outcomes, and built a direct link from debrief findings into the corrective action tracking system.
AFTER	The Monitor reviewed a subsequent near-miss debrief record and traced its finding directly to a specific corrective action that closed the scheduling process gap. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Confirm debriefs are explicitly required for near-misses, not just poor-outcome events.
2. Build a direct link between debrief findings and the corrective action process.
3. Establish and communicate a genuinely blameless debrief approach.

The most common mistake: Reserving formal debriefs for events with an actual poor outcome, missing the valuable lessons available from near-misses that happened to resolve without lasting harm.

SELF-ASSESSMENT QUESTIONS

1. Is a debrief actually conducted after significant events, not skipped if the outcome was ultimately fine? — *A near-miss with a fine outcome still carries lessons worth capturing.*

Evidence: Debrief record

2. Do debrief findings actually feed into corrective action, or do they stay as an informal conversation with no follow-through? — *A debrief with no link to corrective action produces insight that goes nowhere.*

Evidence: Corrective action traceability

3. Is the debrief genuinely blameless, encouraging honest input rather than defensive accounts? — *A punitive debrief environment discourages the honesty needed to actually learn from an event.*

Evidence: Debrief culture assessment

COMMON REASONS FOR A PARTIAL ANSWER

- Near-misses with fine outcomes don't trigger a formal debrief.
- Debrief findings aren't traceable to specific corrective actions.

IMPLEMENTATION PLAN

When	What
Week 1	Extend the debrief requirement explicitly to near-misses.
Week 2	Build a direct link from debrief findings to corrective action tracking.

When	What
Week 3	Communicate and reinforce a blameless debrief approach to all crew.
Ongoing	Review debrief-to-corrective-action traceability periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Debrief-to-action traceability review	Selects a debrief record and traces it to a specific resulting corrective action.

EVIDENCE BASE

Joint Commission International. Accreditation Standards for Medical Transport Organizations, 1st ed. Oak Brook (IL): JCI; 2021.

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