

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 7

Standard 7 — Governance & Management

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

CRITERIA IN THIS STANDARD

7.1 — Named Accountable
Clinical Lead

7.2 — Incident Reporting and
Root-Cause Investigation

7.3 — Internal Audit, On a Fixed
Schedule

7.4 — Complaints Logged,
Investigated, Closed

7.5 — Management Review,
With Minutes and Actions

7.1 Named Accountable Clinical Lead

NON-NEGOTIABLE

A named, currently employed individual holds documented, final clinical accountability for the transport organization's quality and safety, with authority to halt an unsafe transport. Financial accountability is named separately, even where the same person holds both roles, and a brief, genuine statement of mission and values exists for the organization.

In plain terms: One real, current person is clearly on the hook for the organization's clinical quality and safety — not a title left over from someone who's since moved on.

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

WHY THIS MATTERS

A clinical lead title left unassigned after someone departs creates exactly the accountability gap that becomes visible only when something goes wrong and the honest answer to “who owns this” is uncertain. Authority to halt an unsafe transport needs to be genuinely exercisable, not merely written into a job description that’s never actually been tested in practice.

WHAT GOOD LOOKS LIKE

- A current, verifiable individual holds the role, matching employment records.
- Documented authority to halt an unsafe transport exists and has been exercised.
- Crew can correctly name this person without hesitation.

COMMON FAILURE MODES

- A named lead has left the organization and the title was never reassigned.
- Halt authority exists on paper but has never actually been exercised.
- Crew give inconsistent answers about who holds this accountability.

WORKED EXAMPLE

IN PRACTICE

A mid-sized transport organization after a leadership transition.

BEFORE

The organizational chart listed a clinical lead who had left for another position four months earlier. The operations manager had been informally handling clinical decisions without a formal appointment or documented halt authority.

ACTION

Leadership formally appointed the operations manager as Acting Clinical Lead, issued a signed appointment letter with explicit halt authority, updated the organizational chart, and briefed all crew directly.

AFTER

The Monitor asked three crew members who held clinical accountability and all three correctly named the same person with accurate authority description. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check who is actually named as clinical lead and confirm current employment.
2. Issue or update a formal appointment letter with explicit halt authority.
3. Brief crew directly, not relying on an organizational chart update alone.

The most common mistake: Updating the organizational chart but never directly telling crew, who continue naming the previous lead months later when asked.

SELF-ASSESSMENT QUESTIONS

1. Is there a named, current clinical lead, not a title left over from someone who has since left? — *Verified against actual employment records, not an outdated organizational chart.*
Evidence: Current employment record, appointment letter
2. Does this person hold documented authority to halt an unsafe transport before it departs? — *Authority on paper only is not authority.*
Evidence: Signed delegation of authority
3. Can crew correctly name this person if asked directly? — *If frontline crew don't know who it is, the accountability is not functioning in practice.*
Evidence: Crew interview
4. Is financial accountability named separately from clinical accountability, even if held by the same person? — *A distinct, named responsibility, not assumed to be covered by the clinical lead role alone.*
Evidence: Governance role documentation
5. Does a brief, genuine statement of mission and values exist, specific to this organization? — *A real, specific statement, not an absence of one on the assumption a transport service doesn't need it.*
Evidence: Mission/values statement

COMMON REASONS FOR A PARTIAL ANSWER

- An acting lead functions informally without a formal appointment letter.
- Halt authority is assumed rather than explicitly documented.

IMPLEMENTATION PLAN

When	What
Week 1	Verify who is actually, currently accountable.
Week 2	Issue or update the formal appointment letter with explicit authority.
Week 3	Brief all crew directly and update the organizational chart.
Ongoing	Review this appointment whenever the role changes hands.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Crew interview	Asks crew members separately who holds clinical accountability, without prompting.

EVIDENCE BASE

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

7.2 Incident Reporting and Root-Cause Investigation

NON-NEGOTIABLE

Every clinical or safety incident is logged in a single system and investigated to identify root cause, not only the immediate symptom, with corrective action tracked to completion.

In plain terms: Every incident is logged in one place and genuinely investigated for the real reason it happened — not just “crew error” — with fixes actually tracked through to done.

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

WHY THIS MATTERS

“Crew error” as a complete investigation finding is almost always incomplete — what allowed the error to occur is the genuine root cause, and stopping short of identifying it leaves the underlying condition fully intact to produce the same failure again. Fragmented, informal incident tracking across different staff members makes any real trend analysis or systematic investigation effectively impossible.

WHAT GOOD LOOKS LIKE

- A single incident log captures every reported event.
- Investigation identifies root cause beyond “crew error.”
- Corrective action is tracked to actual completion with a named owner.

COMMON FAILURE MODES

- Incidents are tracked informally across different staff, nothing centralized.
- Investigation stops at “crew error” with no deeper analysis.
- Corrective actions are agreed but never tracked through to completion.

WORKED EXAMPLE

IN PRACTICE

A repeated medication administration documentation error.

BEFORE

Two similar documentation errors occurred within a month, each closed with “crew retrained,” with no investigation into why both involved the same busy handoff point between two specific crew pairings.

ACTION

After the second incident, the clinical lead investigated further and found both involved an ambiguous documentation field design that different crew interpreted differently. The corrective action redesigned the field, not just retrained the crew.

AFTER

The Monitor reviewed the investigation record and found a genuine root cause beyond crew error, plus a documented effectiveness check confirming the redesigned field eliminated the recurring error. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a single, centralized incident log if none exists.
2. Review recent incidents for root-cause depth beyond “crew error.”
3. Add a corrective action tracker with named owners and completion dates.

The most common mistake: Closing an incident investigation with “crew retrained” as both the finding and the complete fix, without asking what in the process or design allowed the error to happen in the first place.

SELF-ASSESSMENT QUESTIONS

1. Does a single incident log exist capturing every reported event, not scattered informal records? — *Fragmented, informal tracking makes trend analysis and real investigation impossible.*

Evidence: Incident log

2. Pick a recent incident — does the investigation identify a root cause beyond “crew error”? — *What allowed the error to happen is the root cause, not the error itself.*

Evidence: Investigation record

3. Is corrective action tracked to actual completion, with a named owner and date? — *Agreed actions with no follow-through accomplish nothing.*

Evidence: Corrective action tracker

COMMON REASONS FOR A PARTIAL ANSWER

- Investigations stop at the first obvious explanation.
- Corrective actions are agreed verbally but not formally tracked.

IMPLEMENTATION PLAN

When	What
Week 1	Build or consolidate a single incident log.
Week 2	Train investigators on basic root-cause technique.
Week 3	Build a corrective action tracker with owners and dates.
Ongoing	Review incident trends for recurring patterns.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Incident and corrective action review	Selects a recent incident and assesses root-cause depth and corrective action completion.

EVIDENCE BASE

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

7.3 Internal Audit, On a Fixed Schedule

CORE

The organization’s full operation is internally audited at least annually against a documented schedule, covering vehicles, crew records, and documentation across every base location, not only the most convenient to review.

In plain terms: Every base location gets genuinely audited on a real schedule — not just the main office, with a satellite base conveniently skipped.

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

WHY THIS MATTERS

A satellite or remote base location excluded from audit scope, often simply because it’s less convenient to reach, creates exactly the kind of blind spot where gaps accumulate unnoticed. Audit findings need

enough genuine detail for someone outside the audit to understand what was actually checked, rather than a checklist of ticks with no real substance behind it.

WHAT GOOD LOOKS LIKE • The audit schedule explicitly covers every base location. • The most recent audit actually happened on or near its scheduled date. • Audit findings are detailed enough for someone outside the audit to understand.	COMMON FAILURE MODES • A remote or satellite base is quietly excluded from audit scope. • Audits slip significantly behind schedule with no tracking of the slippage. • Findings are a checklist of ticks with no real substantive detail.
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WORKED EXAMPLE

IN PRACTICE	
<i>An organization with a main base and a smaller satellite location two hours away.</i>	
BEFORE	Three consecutive annual audits covered the main base thoroughly. The satellite base, requiring a longer trip to reach, had never once been included — it simply wasn't on anyone's audit list.
ACTION	The organization built a formal multi-year audit cycle explicitly naming both locations, with the satellite base's audit scheduled on the shared organizational calendar, visible to all staff.
AFTER	The Monitor reviewed the schedule and confirmed the satellite base's first audit had been completed on time, with detailed findings on file. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every base location the organization operates.
2. Check which of these your current or most recent audit actually covered.

3. Build a multi-year cycle that explicitly includes every location.

The most common mistake: A satellite or harder-to-reach base location quietly falls outside the audit scope because nobody explicitly included it when the schedule was first built.

SELF-ASSESSMENT QUESTIONS

1. Does the audit schedule explicitly cover every base location, not only headquarters? — *A satellite or remote base that's never included in audit scope is a specific, checkable gap.*

Evidence: Audit schedule

2. Did the most recent audit actually happen on or near its scheduled date? — *A schedule that's routinely missed is not functioning.*

Evidence: Audit completion records

3. Are audit findings detailed enough that someone outside the audit could understand what was actually checked? — *A checklist with ticks and no detail is not a usable audit record.*

Evidence: Audit report

COMMON REASONS FOR A PARTIAL ANSWER

- **A satellite location was never explicitly added to audit scope.**
- **Audits happen but findings are too brief to act on.**

IMPLEMENTATION PLAN

When	What
Week 1	List every base location requiring audit coverage.
Week 2	Build a multi-year cycle with explicit scheduled dates for each.
Week 3	Share the schedule and assign an auditor to the first session.
Ongoing	Track schedule adherence and escalate any slippage.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Schedule and report review	Checks the audit schedule's completeness against all actual base locations.

EVIDENCE BASE

International Organization for Standardization. ISO 19011:2018, Guidelines for auditing management systems. Geneva: ISO; 2018.

7.4 Complaints Logged, Investigated, Closed CORE

Every complaint, from patient, family, or receiving facility, is logged in a single register, investigated, and closed with a documented outcome communicated back to the complainant where contact information exists.

In plain terms: Every complaint, from anyone, gets written down in one place, actually investigated, and the person who complained finds out what happened.

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

WHY THIS MATTERS

A complaint resolved verbally in the moment, with nothing logged, is effectively invisible to the organization's quality system — it cannot inform trend analysis or prevention, and leaves no record the concern was genuinely taken seriously. Complaints from receiving facilities about handover quality or communication are a particularly direct, valuable signal for this kind of organization, and are easy to lose if not formally captured.

WHAT GOOD LOOKS LIKE

- A single complaints register captures every complaint, regardless of source.
- Each entry has a documented investigation outcome.
- The complainant is informed of the outcome where contact exists.

COMMON FAILURE MODES

- Complaints handled verbally in the moment are never logged.
- Receiving facility complaints about handover quality go uncaptured.
- A complaint is received but the outcome is never communicated back.

WORKED EXAMPLE

IN PRACTICE

A receiving facility raising a concern about handover quality.

BEFORE	A receiving nurse mentioned to crew that a recent handover felt rushed and incomplete. The comment was passed along informally but never formally logged as a complaint, and no investigation followed.
ACTION	The organization built a complaints register explicitly including a category for receiving facility feedback, with crew trained to log any such comment formally rather than treating it as informal conversation.
AFTER	The Monitor reviewed the register and found a subsequent receiving facility complaint logged, investigated, and closed with a callback confirming the outcome to the complainant. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a single complaints register covering all sources, including receiving facilities.
2. Brief crew that informal feedback still counts and needs logging.
3. Build a step to close the loop with the complainant.

The most common mistake: Treating a complaint or concern raised informally, especially from a receiving facility during a routine handover, as a casual comment rather than something requiring formal logging.

SELF-ASSESSMENT QUESTIONS

1. Does a single complaints register exist, or are complaints handled informally by whoever receives them? — *Complaints handled verbally and never logged are effectively invisible to the quality system.*
Evidence: Complaints register

2. Is there a documented outcome for each logged complaint? —

Receipt without resolution is not complaint handling.

Evidence: Investigation outcome record

3. Was the complainant actually informed of the outcome where contact information exists? — *Closing a complaint internally without telling the person who raised it undermines trust.*

Evidence: Callback or communication record

COMMON REASONS FOR A PARTIAL ANSWER

- **Informal feedback from receiving facilities isn't consistently logged.**
- **Outcomes aren't consistently communicated back to complainants.**

IMPLEMENTATION PLAN

When	What
Week 1	Build or consolidate a single complaints register.
Week 2	Brief crew that informal feedback requires formal logging.
Week 3	Add a required closing-the-loop step.
Ongoing	Trend complaint types quarterly for recurring themes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Register review	Selects a logged complaint and verifies investigation outcome and complainant communication.

EVIDENCE BASE

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

7.5 Management Review, With Minutes and Actions STANDARD

Senior management formally reviews organizational quality and safety performance at least annually, with documented minutes covering incidents, complaints, and audit findings, and tracked output actions with owners and dates.

In plain terms: Leadership genuinely sits down once a year, looks at real incident and complaint data, writes down what they decided, and someone checks those decisions actually get done.

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

WHY THIS MATTERS

Management review is where quality data is meant to actually reach the people with authority to allocate resources and set direction. A review that covers operational and budget matters thoroughly while quality-specific inputs — incidents, complaints, audit findings — get only a passing mention isn't functioning as a genuine quality review, regardless of how well-attended the meeting is.

WHAT GOOD LOOKS LIKE

- Documented minutes with named attendees exist for the most recent cycle.
- Minutes specifically cover incidents, complaints, and audit findings.
- Output actions from the previous review are traceable to completion.

COMMON FAILURE MODES

- Review happens but focuses on operations and budget, not quality inputs.
- No written minutes exist, just a verbal assurance it happened.
- Agreed actions from the previous review were never followed up.

WORKED EXAMPLE

IN PRACTICE

An organization's first formal management review cycle.

BEFORE	Annual “management review” consisted of leadership briefly mentioning operational metrics during a general planning meeting, with no structured coverage of incidents, complaints, or audit findings, and no written minutes.
ACTION	The organization instituted a formal annual review with a fixed agenda explicitly covering incidents, complaints, and audit findings, with written minutes and an action tracker assigning owners and dates to every output decision.
AFTER	The Monitor reviewed minutes from the most recent cycle and the action tracker, confirming prior actions were completed on time or had documented, reasonable extensions. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Set a fixed annual date for the formal management review.
2. Build an agenda explicitly covering incidents, complaints, and audit findings.
3. Take real minutes and assign owners to every output action.

The most common mistake: Holding a review that covers operational and budget topics thoroughly while quality-specific inputs like incidents and complaints receive only a brief, passing mention.

SELF-ASSESSMENT QUESTIONS

1. Do management review minutes exist for the most recent cycle, with named attendees? — *Not a verbal assurance that “we discussed it.”*

Evidence: Signed meeting minutes

2. Do the minutes cover incidents, complaints, and audit findings specifically? — *A review that only covers budget and operations is not a quality review.*

Evidence: Meeting agenda and minutes

3. Are output actions from the previous review traceable to completion? — *Actions agreed and never followed up are a common, specific failure.*

Evidence: Action tracker

COMMON REASONS FOR A PARTIAL ANSWER

- Minutes exist but omit specific coverage of quality inputs.
- Actions are agreed verbally but never tracked to closure.

IMPLEMENTATION PLAN

When	What
Week 1	Set the annual review date and build a structured agenda template.
Week 2	Gather required inputs — incident, complaint, and audit data.
Week 3	Hold the review, take formal minutes, assign action owners and dates.
Ongoing	Track output actions to completion before the next cycle.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Minutes and action tracker review	Confirms minutes cover required quality inputs and checks prior action completion status.

EVIDENCE BASE

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

← Medical Transport Standards — all standards

Standard 8 — Refugee & Migrant Health →

ASF STANDARDS · MEDICAL TRANSPORT · STANDARD 8

Standard 8 — Refugee & Migrant Health

4 criteria · 2 non-negotiable · 2 core · Version 1.0

CRITERIA IN THIS STANDARD

**8.1 — No Documentation Status
Barrier to Urgent Transport**

**8.2 — Trauma-Informed
Approach to Transport and
Restraint**

**8.3 — Interpretation Access
During Transport**

**8.4 — Staff Trained on
Migration-Competent Practice**

8.1 No Documentation Status Barrier to Urgent Transport

NON-NEGOTIABLE

Lack of national identification, insurance documentation, or immigration status documentation never delays or blocks an urgent or clinically necessary transport, and dispatch and crew are explicitly trained that this is the rule.

In plain terms: Nobody is denied or delayed an urgent transport because they lack standard documentation — and dispatch staff know, without hesitation, that this is a genuine rule, not a gray area.

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

WHY THIS MATTERS

Hesitation from dispatch staff when asked about this policy is itself a meaningful signal — if staff aren't confident the rule genuinely applies without exception, there's a real risk an undocumented patient faces delay or denial in an actual urgent situation, precisely the outcome this criterion exists to prevent. Removing the documentation barrier to dispatch doesn't mean abandoning identity verification altogether; an alternative, documented verification method still has a role.

WHAT GOOD LOOKS LIKE

- Dispatch staff state clearly, without hesitation, that undocumented status never blocks urgent dispatch.
- A documented instance exists of a transport proceeding without standard documentation.
- Identity is still verified through an alternative, documented method.

COMMON FAILURE MODES

- Dispatch staff hesitate or give an uncertain answer when asked directly.
- No example exists of the policy ever actually being applied.
- Identity verification is dropped entirely rather than handled through an alternative.

WORKED EXAMPLE

IN PRACTICE

A dispatch center reviewing its documentation policy understanding.

BEFORE

The policy existed in writing, but when asked directly, a dispatcher gave an uncertain answer about whether a patient lacking national ID could be dispatched urgently, suggesting they would “probably need to check with a supervisor first.”

ACTION

The organization ran a specific training session reinforcing the policy as an absolute rule requiring no supervisor check, and built an alternative identity-verification method using date

	of birth and name as recorded at the sending facility.
AFTER	The Monitor asked a different dispatcher the same question and received a clear, confident answer with no hesitation about needing approval. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask dispatch staff directly whether undocumented status blocks urgent dispatch.
2. Reinforce the policy as absolute, with no supervisor check required.
3. Build an alternative identity-verification method for undocumented patients.

The most common mistake: A written policy exists, but dispatch staff remain uncertain in practice whether it applies without exception, leading to hesitation and potential delay in an actual urgent situation.

SELF-ASSESSMENT QUESTIONS

1. Can dispatch staff state clearly, without hesitation, that undocumented status does not block urgent transport dispatch? — *Hesitation suggests the policy isn't genuinely embedded in practice.*
Evidence: Dispatch staff interview
2. Is there a documented instance of a transport proceeding for a patient without standard documentation? — *Evidence the policy functions in practice, not only on paper.*
Evidence: Transport record
3. Is patient identity still verified through an alternative, documented method even without standard documentation? — *Removing the documentation barrier does not mean removing identity verification.*
Evidence: Alternative verification procedure

COMMON REASONS FOR A PARTIAL ANSWER

- A policy exists but dispatch staff hesitate when asked directly.
- No alternative identity verification method exists for undocumented patients.

IMPLEMENTATION PLAN

When	What
Week 1	Ask several dispatch staff about the policy to check real confidence.
Week 2	Run reinforcement training confirming the policy as absolute.
Week 3	Build an alternative identity-verification method.
Ongoing	Spot-check dispatch staff confidence periodically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Dispatch staff interview	Asks dispatch staff directly about the documentation policy, checking for confident, hesitation-free answers.

EVIDENCE BASE

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

8.2 Trauma-Informed Approach to Transport and Restraint

NON-NEGOTIABLE

Crew are trained to recognize that prior experiences of detention, forced displacement, or coercive transport may affect a patient’s response to being moved or restraint for safety, and adapt their approach accordingly rather than proceeding identically regardless of history.

In plain terms: Crew understand that a patient’s past experience of detention or forced movement can genuinely affect how they respond to being transported or safely secured — and crew adjust accordingly, rather than treating every patient identically.

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

WHY THIS MATTERS

Vehicle transport and a necessary safety restraint can specifically echo a prior experience of detention or coercive movement for a patient with that history, in a way general cultural-sensitivity training doesn't address. An unexplained safety measure, however clinically benign its actual purpose, can be genuinely distressing to a patient without that explanation, making the simple act of explaining a meaningful, low-cost intervention.

WHAT GOOD LOOKS LIKE

- Crew receive training specific to transport and restraint, not only general awareness.
- The purpose of any safety measure is genuinely explained to the patient first.
- Crew can recognize and appropriately respond to visible trauma-linked distress.

COMMON FAILURE MODES

- Training covers general cultural sensitivity but not transport-specific triggers.
- A safety measure like a stretcher strap is applied without explanation.
- Crew don't recognize distress as trauma-linked and respond ineffectively.

WORKED EXAMPLE

IN PRACTICE

A patient showing distress during a routine stretcher securing procedure.

BEFORE

Crew applied standard stretcher straps without explanation, as was routine practice for every patient, and a patient with a detention history became visibly distressed, which crew initially didn't connect to the restraint-like appearance of the straps.

ACTION

The organization built specific training covering transport and restraint-related trauma triggers, with a standard practice of briefly explaining the

safety purpose of any strap or securing measure to every patient before applying it.

AFTER

The Monitor observed a subsequent transport where crew clearly explained the stretcher strap's safety purpose before applying it, and the patient appeared noticeably more at ease. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build specific training on transport and restraint-related trauma triggers.
2. Make explaining the purpose of any safety measure a standard practice for every patient.
3. Train crew to recognize and appropriately respond to trauma-linked distress.

The most common mistake: Applying a standard safety measure like a stretcher strap without explanation, as routine practice for every patient, missing that this specific action can echo a prior coercive experience for some patients.

SELF-ASSESSMENT QUESTIONS

1. Are crew trained in trauma-informed practice specific to transport and any necessary safety restraint, not just general cultural awareness? — *Vehicle transport and restraint for safety can be a specific trigger point for patients with a detention history.*

Evidence: Training curriculum

2. Is the purpose of any safety measure, such as a stretcher strap, genuinely explained to the patient before it's applied? — *An unexplained restraint-like measure can be distressing regardless of its benign safety purpose.*

Evidence: Direct observation

3. Can crew recognize and appropriately respond to visible distress linked to past trauma during transport? — *A documented, practiced response, not an assumption that crew will improvise appropriately.*

Evidence: Crew interview, response protocol

COMMON REASONS FOR A PARTIAL ANSWER

- Safety measures are applied routinely without explanation to the patient.
- Training covers general cultural sensitivity without transport-specific content.

IMPLEMENTATION PLAN

When	What
Week 1	Build transport and restraint-specific trauma-informed training content.
Week 2	Train all crew and make explanation a standard practice.
Week 3	Build a distress-recognition and response protocol.
Ongoing	Observe practice periodically for consistency.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Transport observation	Observes whether crew explain the purpose of safety measures before applying them.

EVIDENCE BASE

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

8.3 Interpretation Access During Transport CORE

Where crew and patient do not share a language, a practical interpretation method is available and actually used during transport for clinical communication, never relying on a minor child accompanying the patient.

In plain terms: When crew and patient don’t share a language, a real interpretation method is genuinely used — and a child accompanying the patient is never asked to interpret clinical information.

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

WHY THIS MATTERS

Relying on a minor child to interpret clinical information places an inappropriate burden on that child and risks miscommunication of genuinely sensitive medical content — this is a well-established, specific failure mode that this criterion exists to prevent entirely, not merely discourage. A usable interpretation method needs to be genuinely accessible during an actual moving transport, not only something crew could theoretically arrange before departure.

WHAT GOOD LOOKS LIKE

- A practical interpretation method is actually used, verifiable through records.
- No instance exists of a minor child being used to interpret clinical information.
- Crew can describe accessing interpretation mid-transport, not only from base.

COMMON FAILURE MODES

- An interpretation method exists in policy but is rarely actually used.
- A minor child has been used to interpret in a documented or recalled instance.
- Crew don't know how to access interpretation while already en route.

WORKED EXAMPLE

IN PRACTICE

A family accompanying a language-discordant patient on transport.

BEFORE

Crew defaulted to having the patient's teenage child, who spoke better English, relay clinical questions and answers during the journey, since this felt like the path of least resistance in the moment.

ACTION

The organization built an explicit policy prohibiting minor interpretation for clinical content, trained crew on the phone interpretation line as the required alternative, and reinforced this through

the same simplified access process used elsewhere.

AFTER

The Monitor reviewed a subsequent similar transport and found crew used the phone interpretation line directly, with the child not asked to interpret clinical content. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build an explicit policy prohibiting minor interpretation for clinical content.
2. Confirm the interpretation method genuinely works mid-transport, not only pre-departure.
3. Brief crew directly on this as a firm rule, not a preference.

The most common mistake: Defaulting to a patient's accompanying child as an informal interpreter because it feels like the easiest option in the moment, rather than using the organization's actual interpretation resource.

SELF-ASSESSMENT QUESTIONS

1. Is a practical interpretation method actually used, verifiable through records, not just available in policy? — *Verified against actual recent use, not only the existence of a resource.*

Evidence: Usage log

2. Is there any documented instance of a minor child being used to interpret clinical information? — *A single such instance is a direct, serious failure of this criterion.*

Evidence: Incident review, if applicable

3. Can crew describe how to access interpretation during a moving transport, not only from base? — *The method needs to be genuinely usable mid-route, not only before departure.*

Evidence: Crew interview

COMMON REASONS FOR A PARTIAL ANSWER

- Crew default to family interpretation, including minors, as the easier option.
- The interpretation method isn't genuinely accessible mid-transport.

IMPLEMENTATION PLAN

When	What
Week 1	Build an explicit policy prohibiting minor interpretation for clinical content.
Week 2	Confirm and simplify mid-transport interpretation access.
Week 3	Brief all crew directly on the firm rule.
Ongoing	Spot-check interpretation usage records.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Crew interview	Asks crew to describe mid-transport interpretation access and confirms awareness of the minor-interpretation prohibition.

EVIDENCE BASE

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

8.4

Staff Trained on Migration-Competent Practice

CORE

Crew and dispatch staff receive specific training on migration- and displacement-competent practice — not general cultural-sensitivity training alone — covering trauma-informed transport, interpreter use, and documentation-status awareness.

In plain terms: Crew and dispatch get training specifically designed for migration and displacement contexts — not a generic customer-service cultural-sensitivity course that doesn’t actually address what this standard covers.

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

WHY THIS MATTERS

General cultural-sensitivity training, while valuable in its own right, typically doesn't cover the specific content this standard addresses — trauma-informed transport technique, interpreter access, and documentation-status awareness. Training delivered once at hiring and never revisited tends to fade, particularly for content that isn't reinforced through everyday practice, which is why a genuine refresh schedule matters here as much as the initial training itself.

WHAT GOOD LOOKS LIKE • Training specifically addresses migration and displacement contexts. • All crew and dispatch staff complete it, not only a subset. • Training is refreshed on a schedule, not delivered once and forgotten.	COMMON FAILURE MODES • Generic cultural-sensitivity content is used as a substitute for specific training. • Some crew or dispatch staff were hired after the last training round and missed it. • Training happened once at hiring with no refresher since.
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WORKED EXAMPLE

IN PRACTICE <i>An organization reviewing its migration-competence training coverage.</i>	
BEFORE	A general cultural-sensitivity module, part of standard onboarding, was treated as satisfying this requirement, though it didn't specifically cover trauma-informed transport technique, interpreter access, or documentation-status awareness.
ACTION	The organization built a specific migration-competent practice module covering all three required areas, required for every crew and dispatch staff member, with a two-year refresh cycle and a tracking system flagging anyone overdue.

AFTER

The Monitor reviewed the training tracking system and found complete coverage across all current crew and dispatch staff, with refreshers current. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether current training specifically covers migration and displacement content, not just general cultural sensitivity.
2. Build or source a specific migration-competent practice module.
3. Build a tracking system covering all crew and dispatch staff, with a refresh schedule.

The most common mistake: Treating a general cultural-sensitivity onboarding module as sufficient to meet this standard, when it typically doesn't cover the specific trauma-informed transport, interpreter, and documentation-status content this criterion requires.

SELF-ASSESSMENT QUESTIONS

1. Does training specifically address migration and displacement contexts, distinct from generic customer-service content? — *General cultural-awareness training alone does not cover the specific issues this standard addresses.*

Evidence: Training curriculum

2. Is this training completed by all crew and dispatch staff, not only a subset? — *Any staff member in direct patient contact or making dispatch decisions needs this training.*

Evidence: Training completion tracker

3. Is the training refreshed on a schedule, not delivered once at hiring and never revisited? — *A single onboarding session years ago does not keep practice current.*

Evidence: Refresh schedule and completion log

COMMON REASONS FOR A PARTIAL ANSWER

- **Generic cultural-sensitivity content is treated as equivalent to specific training.**
- **Coverage gaps exist for staff hired after the last training round.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current training content against the three required areas.
Week 2	Build or source a specific migration-competent practice module.
Week 3	Roll out to all current crew and dispatch staff, build a tracking system.
Ongoing	Refresh on a fixed schedule and track new-hire completion.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Training tracker review	Checks the training completion tracker for full coverage and current refresh status.

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 8 standards
- ← All ASF Standards