

Medical Transport Standards

The ASF accreditation standard for inter-facility and inter-city patient transport — ambulance services, medical transport organizations, and transport divisions of hospitals and clinics. Every criterion is published in full. Free. No account required.

11 standards · 52 criteria · 19 non-negotiable · 20 core · 13 standard-level · Version 3.0 · Complete, full guidance depth

STANDARD 1 · MANDATORY

Vehicle & Equipment Readiness

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.

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.
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.
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.

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.

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.
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.
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.

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.

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.
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.
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.

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.

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.
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.
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.

STANDARD 2

Crew Qualification & Competence

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.

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

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.

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

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.

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.

2. Is training refreshed on a schedule, not completed once at hiring? — Driving habits can drift without periodic reinforcement.
3. Are drivers briefed on known hazards for regularly traveled routes? — Route-specific knowledge, not generic driving competence alone.

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.

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.
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.
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.

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.

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

STANDARD 3

Patient Assessment & Fitness for Transport

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.

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.
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.
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.

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.

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.

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

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.

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.
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.
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.

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.

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.
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.
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.

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.

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

STANDARD 4

Handover & Communication

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.

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.
2. Does the handover cover allergies and specific concerns explicitly, not just general diagnosis? — These are commonly the details lost in an informal handover.
3. Is the handover documented, with both parties' acknowledgment? — An undocumented handover leaves no record if information was missed.

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.

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

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.

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.
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.
3. Is there a documented instance of this escalation procedure actually being used? — Evidence the procedure functions, not just exists on paper.

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.

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

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.

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

STANDARD 5

Infection Prevention & Control

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.

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.
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.
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.

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.

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

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.

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.
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.
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.

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.

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.
2. Is disposal documented through a licensed pathway, not an informal arrangement? — A disposal manifest or equivalent record, verifiable on request.
3. Are sharps containers replaced before reaching unsafe fill levels? — An overfilled container in a moving vehicle is a specific, elevated risk.

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.

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.
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.
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.

STANDARD 6

Emergency Response During Transport

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.

1. Can crew describe the stop-versus-continue decision criteria without hesitation? — Hesitation in an actual cardiac arrest costs time that directly affects outcome.
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.
3. Is there a documented instance of this protocol being followed during an actual event? — Where none has occurred, confirm the drill record instead.

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.

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

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.

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.

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

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.

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

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.

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.
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.
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.

STANDARD 7

Governance & Management

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.

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.
2. Does this person hold documented authority to halt an unsafe transport before it departs? — Authority on paper only is not 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.
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.
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.

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.

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

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.

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

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.

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.
2. Is there a documented outcome for each logged complaint? — Receipt without resolution is not complaint handling.
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.

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.

1. Do management review minutes exist for the most recent cycle, with named attendees? — Not a verbal assurance that "we discussed it."
2. Do the minutes cover incidents, complaints, and audit findings specifically? — A review that only covers budget and operations is not a quality review.
3. Are output actions from the previous review traceable to completion? — Actions agreed and never followed up are a common, specific failure.

STANDARD 8

Refugee & Migrant Health

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.

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.
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.
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.

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 restrained for safety, and adapt their approach accordingly rather than proceeding identically regardless of history.

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.
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.
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.

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.

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.
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.
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.

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.

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.
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.
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.

STANDARD 9

Sustainable Care

9.1 Fleet Fuel Consumption and Emissions Are Genuinely Tracked, Not Left Unmeasured

CORE

Fleet fuel consumption and emissions are genuinely tracked across the vehicle fleet — not an unexamined, unmeasured cost of operating a transport service, with no real data informing whether consumption is reasonable or improving.

1. Is fleet fuel consumption genuinely tracked across the fleet? — A real, documented tracking system.
2. Is this data genuinely reviewed on a real, defined schedule, not collected and left unexamined? — A real, periodic review.
3. Is there a real, documented instance of this data genuinely informing a decision? — A concrete, real example.

9.2 Route and Dispatch Planning Genuinely Considers Fuel Efficiency

STANDARD

Route and dispatch planning genuinely considers fuel efficiency alongside response time and patient need — not efficiency treated as entirely secondary with no genuine attention at all, while recognising that patient need and response time genuinely come first.

1. Does dispatch planning genuinely factor in fuel efficiency where this doesn't compromise response time or patient need? — A real, considered balance, with patient need always genuinely protected first.
2. Is there a real, documented instance of a routing or dispatch adjustment genuinely improving efficiency? — A concrete, real example.
3. Is unnecessary vehicle idling genuinely addressed as part of this consideration? — A real, considered practice, not an overlooked, routine source of waste.

9.3 Vehicle Procurement and Maintenance Genuinely Consider Environmental Impact

STANDARD

Decisions about vehicle procurement and maintenance genuinely factor in environmental impact and fuel efficiency alongside cost and clinical suitability — not sustainability treated as entirely irrelevant to fleet decisions.

1. Does vehicle procurement genuinely weigh environmental impact alongside cost and clinical suitability? — Real, documented consideration.

2. Is maintenance genuinely proactive for fuel efficiency, not purely reactive to breakdowns? — A real, proactive maintenance practice.
3. Is there a real, documented instance of environmental impact genuinely influencing a fleet decision? — A concrete, real example.

9.4 Crew Are Genuinely Engaged in Sustainability Practice

STANDARD

Crew genuinely understand and participate in the service's sustainability practices — not a policy known only to management with no real reach to a workforce that spends most of its time on the road, away from any shared office.

1. Can crew asked directly describe at least one genuine sustainability practice? — Real, demonstrated awareness, not a policy known only to management.
2. Is crew input genuinely sought on practical, road-level sustainability measures? — Real, two-way engagement, drawing on crew who genuinely know actual driving conditions.
3. Does this communication genuinely reach crew who rarely visit a central office? — Real, functioning communication appropriate to a road-based workforce.

9.5 Sustainability Commitments Are Genuinely Reviewed, Not Static

STANDARD

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

1. Are sustainability goals genuinely reviewed on a real, defined schedule? — A real, periodic review.
2. Is there a real, documented instance of a goal genuinely being revised based on actual experience? — A concrete, real example.
3. Is responsibility for this review genuinely assigned to a specific person or role? — A real, named accountability.

STANDARD 10

Digital Care and Artificial Intelligence

10.1 Dispatch and Routing Systems Are Genuinely Evaluated for Reliability

CORE

The dispatch and routing system is genuinely evaluated for reliability before and during use, with a real, functioning fallback when it fails — not a single point of failure that, if it goes down, genuinely leaves crews without a way to receive or respond to calls.

1. Is the dispatch system genuinely evaluated for reliability? — A real, documented evaluation.
2. Is there a genuine, functioning fallback when the dispatch system fails? — A real, usable backup, not an untested assumption.
3. Is there a real, documented instance of the fallback genuinely being used, successfully? — A concrete, real example, not a plan never actually tested.

10.2 Patient Data Transmitted Electronically Is Genuinely Secure

CORE

Patient data transmitted electronically between the vehicle, dispatch, and the receiving facility is genuinely secure — not sent over an unsecured channel on the assumption that the urgency of transport makes security a secondary concern.

1. Is patient data transmitted electronically genuinely secure? — Real, verified security.

2. Is crew genuinely trained on secure data handling specific to mobile, on-the-road transmission? — Real, setting-specific training.
3. Is there a genuine process for reporting a suspected data security issue? — A real, usable reporting pathway.

10.3 Route Optimisation Tools Never Override Genuine Clinical Judgement

STANDARD

Where route optimisation or AI-assisted dispatch tools are used, crew and dispatch staff genuinely retain the authority to override a suggested route or decision based on real clinical or situational judgement — not a tool's output treated as binding regardless of real, on-the-ground circumstances the tool cannot see.

1. Can crew and dispatch staff genuinely override a tool's suggested route or decision? — A real, functioning override capability.
2. Are staff genuinely aware they have this authority, not assuming the tool's output must be followed? — Real, demonstrated staff understanding.
3. Is there a real, documented instance of a genuine override based on real-world circumstances? — A concrete, real example.

STANDARD 11

Supporting the Care Workforce

11.1 A Safety or Welfare Concern Can Genuinely Be Raised Without Fear of Reprisal

CORE

A genuine, protected process exists for crew to raise a safety or welfare concern — including about a vehicle defect, a dangerous dispatch decision, or pressure to drive while fatigued — with real protection from adverse treatment, not a reporting line that exists on paper with no real, demonstrated protection.

1. Is there a genuine, accessible process for crew to raise a safety or welfare concern? — A real, known process.
2. Are crew genuinely protected from adverse treatment when raising a concern, including about a dispatch decision? — Real, demonstrated protection.
3. Is there a real, documented instance of a raised concern genuinely leading to a real investigation and resolution? — Genuine follow-through.

11.2 Exposure to Traumatic or Distressing Calls Is Genuinely Supported

CORE

Crew who respond to traumatic or distressing calls genuinely have access to real psychological support — not an unexamined assumption that crew simply develop resilience over time with no real, structured support offered.

1. Do crew genuinely have access to psychological support after a traumatic or distressing call? — Real, accessible support.
2. Is support genuinely offered proactively, not only if a crew member specifically requests it? — A real, proactive offer, recognising crew may not always genuinely recognise or voice their own need.
3. Can a crew member describe a real instance of this support genuinely making a difference? — A real, concrete example.

11.3 Road Incidents and Near-Misses Are Genuinely Reported and Reviewed

STANDARD

A genuine process exists for crew to report a road incident or near-miss — including one caused by their own error — with a real, blame-aware review focused on genuine system improvement, not a punitive process that genuinely discourages honest reporting.

1. Is there a genuine, accessible process for crew to report a road incident or near-miss? — A real, known process.
2. Is review genuinely focused on system improvement, not immediate individual blame? — A real, blame-aware approach, encouraging genuinely honest reporting.
3. Is there a real, documented instance of a near-miss report genuinely leading to a system change? — A concrete, real example.

11.4 Crew Have Genuine Access to Ongoing Education Beyond Mandatory Certification

STANDARD

Every crew member has genuine access to ongoing professional education beyond mandatory certification renewal covered under Standard 2 — not education treated as complete once minimum regulatory requirements are met.

1. Does every crew member have genuine, ongoing access to education beyond mandatory certification? — Real, continuing access.
2. Can a crew member describe a genuine education opportunity taken in the past year? — A real, specific example.
3. Is this access genuinely equitable across shifts, including night and weekend crew? — Real, equitable access.

11.5 Crew Feedback Is Genuinely Gathered and Acted On

STANDARD

The service has a genuine, systematic approach to gathering feedback from its crew, with real analysis and a genuine, implemented response — not feedback collected occasionally with no real pattern of actual improvement, particularly important given the genuine absence of informal, in-person feedback moments a road-based workforce naturally lacks.

1. Is crew feedback genuinely gathered on a systematic, recurring basis? — Real, ongoing collection.
2. Is collected feedback genuinely analysed for trends? — A real, documented analysis process.
3. Is there a documented instance where feedback genuinely led to an implemented change? — A real, concrete example.

11.6 Equality, Diversity and Inclusion Across the Workforce Are Genuinely Monitored

STANDARD

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

1. Is workforce data on recruitment, work allocation, scheduling, and promotion genuinely monitored for patterns of inequity? — A real, documented monitoring process, not an assumption that fairness exists by default.
2. Where a genuine pattern is identified, is there a real, defined response? — A genuine corrective process, not data collected with no real follow-through.
3. Is there a real, documented instance of this monitoring genuinely informing a change in practice? — A concrete, real example.